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SECTION B: CAPITATION RATES

CRSA shall provide services described in this contract. In consideration for these services, CRSA will be paid as described in Section D: Program Requirements, Paragraph 26 Compensation. For the term July 1, 2005 through June 30, 2006, CRSA will be paid the capitation rates shown below for CRS eligible AHCCCS members, subject to review by the Joint Legislative Budget Committee and the Centers for Medicare and Medicaid.

SECTION C: DEFINITIONS

ACOM	<i>AHCCCS Contractor Operations Manual</i> , available on the AHCCCS Website at www.azahcccs.gov .
ADHS	Arizona Department of Health Services.
AHCCCS	Arizona Health Care Cost Containment System as defined by ARS §36-2901.
AHCCCSA	Arizona Health Care Cost Containment System Administration.
AHCCCS MEMBER	See "MEMBER."
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCSA that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by ARS §36-2932 et seq.
AMPM	The <i>AHCCCS Medical Policy Manual</i> .
ARIZONA ADMINISTRATIVE CODE (AAC)	State regulations established pursuant to relevant statutes. For purposes of this contract, the relevant sections of the AAC are referred to throughout this document as "AHCCCS Rules."
ARS	Arizona Revised Statutes.
BIDDER'S LIBRARY	A repository of manuals, statutes, rules and other reference material located at the AHCCCSA. A limited, virtual library is located on the AHCCCS website at www.azahcccs.gov .
CAPITATION	Payment to contractor by AHCCCSA of a fixed monthly payment per person in advance for which the contractor provides a full range of covered services as authorized under ARS § 36-2942 and § 36-2931.
CLAIM DISPUTE	A dispute filed by a provider or a health plan/program contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by ARS § 36-2904.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
CONTRACT YEAR (CY)	Corresponds to state fiscal year (July 1 through June 30).
CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCSA to provide the goods and services specified by this contract in conformance with the stated contract requirements, AHCCCS statute and rules and Federal law and regulations. For purposes of this contract, CRSA and Contractor have the same meaning.
COPAYMENT	An amount which the member pays directly to a provider at the time covered services are rendered.

COVERED SERVICES	Health and medical services to be delivered by CRS which is designated in A.A.C. Title 9 Chapter 7 Article 4 et seq.
CRS	Children's Rehabilitative Services.
CRS ELIGIBLE	An individual who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS related services.
CRS RECIPIENT	A CRS recipient is a CRS eligible individual who has completed the initial medical visit at an approved CRS Clinic, which allows the individual to participate in the CRS program.
CRSA	Children's Rehabilitative Services Administration.
CYE	Contract Year Ended; same as "CONTRACT YEAR."
DAYS	Calendar days unless otherwise specified in the text, as defined in R9-22-101.
DIRECTOR	The Director of AHCCCSA.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or, c) serious dysfunction of any bodily organ or part. 42 CFR 438.114(a)
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. 42 CFR 438.114(a)
ENCOUNTER	A record of a health care related service, submitted by CRSA and processed by AHCCCS, which is rendered by a provider registered with AHCCCS to a CRS recipient on the date of service, and for which a CRS subcontractor incurs any financial liability.
ENROLLEE	A Medicaid recipient who is currently enrolled with a health plan or program contractor. For purposes of this contract, see definition of Member. 42 CFR 438.10(a)
ENROLLMENT	The process by which an eligible person becomes an enrollee of a health plan or program contractor.
FEDERAL FINANCIAL PARTICIPATION (FFP)	The Federal matching rate that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS as defined in 42 CFR 400.203.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
KIDSCARE	Individuals under the age 19, eligible under the State Children's Health Insurance Program (SCHIP), in households with income at or below 200% FPL. All members, except Native American members are required to pay a premium amount based on

	the number of children in the family and the gross family income. Also referred to as Title XXI.
MATERIAL OMISSION	Facts, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a state-operated medical assistance program for specified populations.
MEDICAL EXPENSE DEDUCTION (MED)	Title XIX Waiver member whose family income is more than 100% of the Federal Poverty Level (FPL) and has family medical expenses that reduce income to or below 40% of the FPL. MEDs may have a categorical link to a Title XIX category; however, their income exceeds the limits of the Title XIX category.
MEDICARE PART D EXCLUDED DRUGS	Medicare Part D is the Prescription Drug Coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit will not be covered by AHCCCS post January 1, 2006. There are certain drugs that are excluded from coverage by Medicare, and will continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D Health Plan's formulary are not considered excluded drugs, and will not be covered by AHCCCS.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEDICARE MEMBER	A Federal program authorized by Title XVIII of the Social Security Act, as amended. For this contract, a person eligible for AHCCCS who is enrolled with a contractor.
NOTICE OF APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
PMMIS	AHCCCSA's Prepaid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized so that the member could alternatively be safely discharged or transferred to another location. 42 CFR 438.114(a)
POTENTIAL ENROLLEE	A Medicaid eligible recipient who is not enrolled with an acute care/ALTCS contractor [42 CFR 438.10(a)].
PRIMARY CARE PROVIDER/ PRIMARY CARE PRACTITIONER (PCP)	An individual who meets the requirements of ARS § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to ARS Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under ARS Title 32, Chapter 25, or a certified nurse practitioner licensed under ARS Title 32, Chapter 15.

PROVIDER	A person or entity that subcontracts with CRSA, or its delegate, to provide AHCCCS covered services directly to members.
SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act. The Arizona version of SCHIP is referred to as "KidsCare." See "KIDSCARE."
SCOPE OF SERVICES	See "COVERED SERVICES."
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that required by members generally. All CRS recipients are considered to be members with special health care needs.
STATE	The State of Arizona.
STATE FISCAL YEAR (FY)	The budget year-State fiscal year: July 1 through June 30.
SUBCONTRACT	An agreement entered into by CRSA with a provider of health care services who agrees to furnish covered services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for CRSA specifically related to fulfilling CRSA's obligations to AHCCCSA under the terms of this contract.
SUBCONTRACTOR	(1) A person, agency or organization to which CRSA has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or (2) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS contract.
THIRD PARTY	An individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member, as defined in R9-22-1001.
THIRD PARTY LIABILITY	The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member, as defined in R9-22-1001.
TITLE XIX MEMBER	A member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under the 1931 provisions of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
TITLE XIX WAIVER MEMBER	All MED (Medical Expense Deduction) members, and adults or childless couples at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. This would also include Title XIX linked individuals whose income exceeds the limits of the categorical program.
TITLE XXI MEMBER	See "KIDSCARE."

SECTION D: PROGRAM REQUIREMENTS

1. SCOPE OF RESPONSIBILITY

Arizona Department of Health Services/Children's Rehabilitative Services Administration (ADHS/CRSA) shall be responsible for the performance of all contracted requirements. CRSA may delegate responsibilities for services and related activities under this contract, but remains ultimately responsible for compliance with the terms of this contract. 42 CFR 438.230(a)

2. SCOPE OF SERVICES

Children's Rehabilitative Services (CRS) shall provide medically necessary CRS covered services to AHCCCS members, including emergency services related to CRS conditions, when the provider that furnishes the service has an agreement with CRS. For emergency services rendered outside the CRS network, CRSA shall coordinate services with the CRS recipient's acute or long-term care health plan. A complete description of AHCCCS covered services can be found in the AHCCCS Medical Policy Manual (AMPM). Not all AHCCCS covered services are covered by CRS. CRS covered services are described in the Arizona Department of Health Services/Children's Rehabilitative Services Rules R9-7 Article 4 and in the *CRSA Policy and Procedure Manual*.

CRSA and its subcontractors shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. CRSA or its subcontractors shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the recipient [42 CFR 438.210(a)(1), (3)(i), and (4)] unless it is outside the scope of CRSA covered services. CRSA must notify the AHCCCS Health Plan or ALTCS Program Contractor as described in Section D, Paragraph 7, Denials or Reductions of Services. CRSA or its subcontractors may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

CRSA and its subcontractors shall ensure that providers are not restricted or inhibited in any way from communicating freely with recipients regarding the recipients' health care, medical needs and treatment options even if the medical services are not covered by CRS. CRS shall allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the recipient to obtain one outside the network, at no cost to the recipient [42 CFR 438.206(b)(3)].

CRSA must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide, reimburse for, or provide coverage of a covered counseling or referral service. Notification must be submitted prior to entering into a contract with AHCCCS or whenever it adopts the policy during the term of the contract. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to CRS recipients during their initial appointment; and must be provided to CRS recipients at least 30 days prior to the effective date of the policy.

Per the Balanced Budget Act of 1997, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency and post stabilization services except where otherwise noted in the contract. CRS must cover and pay for post-stabilization care services without authorization, when the provider that furnishes the service has a contract with CRS, for the following situations:

1. Post-stabilization care services that were pre-authorized by CRS;
2. Post-stabilization care services that were not pre-approved by CRS because CRS did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or,
3. CRS' representative and the treating physician cannot reach agreement concerning the recipient's care and a CRS physician is not available for consultation. In this situation, CRS must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the recipient until a contracted physician is reached or one of the criteria in CFR 422.113(c)(3) is met.

Pursuant to CFR 422.113(c)(3), CRS' financial responsibility for post-stabilization care services that have not been pre-approved ends when:

1. A contracted physician with privileges at the treating hospital assumes responsibility for the recipient's care;
2. A contracted physician assumes responsibility for the recipient's care through transfer;
3. A representative of CRS and the treating physician reach an agreement concerning the recipient's care; or,
4. The recipient is discharged.

3. COORDINATION OF CARE

CRSA and its subcontractors and AHCCCS and its contracted health plans/program contractors shall ensure the coordination of covered medical services. CRSA shall provide to AHCCCSA, for distribution to health plans and program contractors, a written description of services available for specified CRS covered conditions. The written description of services shall include diagnostic, therapeutic and restorative services available, as well as limitations and exclusions for each CRS covered condition, duration of service coverage, criteria used to determine service limitations and any differences in service coverage for AHCCCS members who are acute care members as opposed to those in long term care. CRSA shall describe which CRS services are subsidiary to other program(s) and conditions that must be met before CRS coverage begins. CRSA shall submit this written description by July 1 and any subsequent changes to AHCCCSA, Division of Health Care Management (DHCM) for review and approval prior to the implementation.

CRSA shall provide to AHCCCSA, DHCM, a clinic contact list within 30 days of the signing of this contract and by July 1 annually. This list shall include the clinic name, the clinic manager and medical director, address, phone numbers, and clinic days and hours. CRSA shall update this contact list quarterly or more frequently if necessary. AHCCCSA shall provide this contact list to health plans/program contractors.

For those AHCCCS members eligible for CRS care, CRSA or its subcontractors shall provide a consultation report to the referring physician and the health plan/program contractor within 30 days of the first visit. The report shall include the plan of care, a diagnosis, and name, address, and phone number of the CRS provider. On a monthly basis CRSA, or its subcontractors, shall submit to the health plan/program contractor's Medical Director, or designee, information that will include, but is not limited to, the recipient's scheduled appointments, whether the appointments were kept, which clinic the recipient is attending and the status of the recipient.

CRSA shall establish policies and procedures for ensuring implementation and monitoring of coordination between subcontractors, AHCCCS acute contractors, and other State agencies. CRSA shall

ensure that in the process of coordinating care, each recipient's privacy is protected in accordance with the privacy requirements in CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable [42 CFR 438.224].

4. ADMINISTRATIVE COORDINATION

CRSA and AHCCCSA shall meet periodically to review administrative and operational issues. CRSA shall provide AHCCCSA with copies of proposals for legislative changes, Arizona Administrative Code program initiatives and any other policy initiatives that may affect CRS services, coverage or other aspects of medical care.

CRSA shall coordinate with AHCCCSA on the development of any Request for Proposals (RFPs) soliciting offers from entities wishing to contract to provide covered services as described in this contract. The coordination shall be designed to ensure that issues relevant to AHCCCS services and members are adequately addressed in the RFPs. CRSA shall submit to AHCCCSA for review and comment, the draft CRS RFP for the provision of CRS services at least 45 days prior to release.

5. AHCCCS POLICY MANUALS

The *AHCCCS Medical Policy Manual (AMPM)* and the *AHCCCS Contractor Operations Manual (ACOM)* are hereby incorporated by reference into this contract. CRSA is responsible for complying with the requirements set forth in Chapters 400, 500, 600, 900 and 1000. The *AMPM and ACOM*, with search capability and linkages to AHCCCS rules, Statutes and other resources, is available to all interested parties through the AHCCCS Home Page on the Internet at <http://www.azahcccs.gov>. Upon adoption by AHCCCSA, *AMPM and ACOM* updates will be available through the Internet at the beginning of each month. CRSA shall be responsible for maintaining such copies current with these updates. CRSA shall require that subcontractors also maintain updated copies of the *AMPM and ACOM*.

6. ELIGIBILITY FOR SERVICES

CRS serves individuals with chronic and disabling or potentially disabling medical conditions who:

- a. Require an interdisciplinary approach to care;
- b. Require multi-specialty physician services or require specialty care which may be provided through the CRS service system; and,
- c. Require expertise which is best developed and maintained through a center of excellence system supported by CRS.

CRSA shall develop and maintain a policy that contains all medical eligibility criteria. CRSA must submit the policy by July 1, and any subsequent changes, to AHCCCSA for review and approval prior to the implementation. CRSA shall ensure that each subcontractor is issued a copy of the policy. The CRSA policy shall be available on the CRSA website at: http://www.azdhs.gov/phs/ocshcn/crs/crs_az.htm, and must be updated as soon as practicable.

Referral: CRSA shall maintain a process for AHCCCS health plans/program contractors to refer members to CRS. CRSA shall make referral forms available to health plans/program contractors. CRSA shall, based on the diagnosis, determine CRS medical eligibility.

Disposition of Referral: Upon reviewing the referral, CRSA or its subcontractor shall inform the referring physician and the health plan/program contractor within 10 working days of receipt of referral, in writing as to whether the member may be eligible for CRS services. If CRSA determines that the member may be eligible for CRS services, the written notice must include the scheduled appointment for the Initial Evaluation. . For the purposes of this contract, the Initial Evaluation is an examination of a member by CRSA or its subcontractor to determine whether the member meets the medical eligibility requirement for participating in the CRS program. The Initial Evaluation shall be scheduled within 30 calendar days of determining that the member may be eligible for CRS services.

Identification of a member as a CRS recipient: Upon completion of the Initial Evaluation, the member shall be considered a CRS recipient if CRSA determines that the member meets the medical eligibility requirement for participating in the CRS program. The effective date of identifying a member as a CRS recipient shall be as soon as practicable.

- a. Notification to AHCCCS: Upon identification of a member as a CRS recipient, CRSA shall notify AHCCCSA via the Recipient Roster Reconciliation tape. AHCCCSA will post a CRS indicator on health plan/program contractor enrollment notification file.
- b. Notification to the Health Plan/Program Contractor: Upon identification of a member as a CRS recipient, CRSA shall notify the health plan/program contractor via the Data Sharing Worksheet.
- c. Data Sharing: CRSA shall ensure that when members are identified as CRS recipients, the information is included in the next reporting cycle of the Data Sharing Worksheet as described in the AHCCCS CRSA/Acute Health Plan and Long Term Care Program Contractor Data Sharing Policy.

Notification to the health plan/program contractor when CRSA determines that the member does not meet the medical eligibility requirements for participating in the CRS program: Upon determining that the member does not meet the medical eligibility requirement for participating in the CRS program, , CRSA shall inform the referring physician and the applicable health plan/program contractor, in writing, of the denial, the reason for the denial and the procedure for filing an appeal, within 5 working days of the denial.

CRSA shall not deny or delay eligibility determination or delivery of services to AHCCCS eligible members due to issues related to CRSA's State funding.

7. DENIALS OR REDUCTIONS OF SERVICES

Service Authorization Requests: For the processing of requests for initial and continuing authorizations of services, CRSA and its subcontractors shall have in place, and follow, written policies and procedures [42 CFR 438.210(b)(1)]. CRSA and its subcontractors shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the recipient's condition or disease [42 CFR 438.210(b)(3)].

In the event that CRSA or its subcontractor fails to render a timely response to a service authorization request from a health plan/program contractor, the health plan/program contractor may review the request

and issue a prior authorization determination. In this instance, CRSA cannot contest the health plan/program contractor's prior authorization determination. If the AHCCCS hearing Decision determines that the service should have been provided by CRSA, CRSA shall be financially responsible for the costs incurred by the health plan/program contractor in providing the service.

Notice to recipients: When any CRS covered service subject to prior authorization is denied, reduced, suspended or terminated, CRSA or its subcontractors shall comply with the Notice of Action and related requirements as detailed in 42 CFR 438.210, 438.400 et seq, Attachment C(1), and AHCCCS Contractor Operations Manual.

Notice to health plans/program contractors: When CRSA or its subcontractor denies a request for a service solely because the requested service is not a CRS covered service, a copy of the Notice of Action must be sent to the ALTCS/Acute Care Contractor in accordance with the AHCCCS Contractor Operations Manual. The notification shall meet the requirements of 42 CFR 438.404, except for the requirement that the notice to the provider be in writing. The notification shall also inform the Medical Director of the health plan/program contractor of the right to request a review of a CRSA's decision in writing with the Medical Director of CRSA no later than 15 working days of the date of the decision.

The CRSA Medical Director shall issue a written decision to the Medical Director of the health plan/program contractor not later than ten (10) working days from the date of receipt of the Request for Review. The decision shall contain language that informs the Medical Director of the health plan/program contractor of his/her right to file a Request for Hearing with AHCCCS, Office of Legal Assistance, not later than thirty (30) days from receipt of the written Notice of Appeal Resolution rendered by CRSA. If the AHCCCS Hearing Decision determines that the service should have been provided by CRSA, CRSA shall be financially responsible for the costs incurred by the health plan/program contractor in providing the service.

Delegation to subcontractors: CRSA may choose to delegate this responsibility to its subcontractors. However, CRSA shall remain responsible for monitoring its subcontractors to ensure all notification requirements are met.

8. MAINSTREAMING OF CRS RECIPIENTS

To ensure mainstreaming of CRS Recipients, CRSA shall take affirmative action so that recipients are provided CRS services without regard to payer source, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated. CRSA must take into account a recipient's culture, when addressing recipients and their concerns, and must ensure its subcontractors do the same.

Examples of prohibited practices include, but are not limited to, the following:

- a. Denying or not providing a recipient any covered service or access to an available facility;
- b. Providing to a recipient any covered service that is different, or is provided in a different manner, or at a different time from that provided to other recipients, other public or private patients or the public at large, except where medically necessary;
- c. Subjecting a recipient to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a recipient in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and,
- d. The assignment of times or places for the provision of services on the basis of the race, color, creed,

religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental handicap of the participants to be served.

If CRSA knowingly executes a subcontract with a provider or entity with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some recipients), CRSA will be in default of this contract.

If CRSA identifies a problem involving discrimination by one of its subcontractors, it shall promptly intervene and implement a corrective action plan. Failure to take prompt corrective measures may place CRSA in default of its contract.

9. RECIPIENT INFORMATION

All informational materials shall be reviewed for accuracy and approved by CRSA prior to distribution to recipients.

All materials shall be translated when CRSA is aware that a language is spoken by 3,000 or 10% (whichever is less) of CRSA's recipients who also have Limited English Proficiency (LEP) in that language.

All vital materials shall be translated when CRSA is aware that a language is spoken by 1,000 or 5% (whichever is less) of CRSA's recipients who also have LEP in that language [42 CFR 438.10(c)(3)]. Vital materials must include, at a minimum, Notices of Action, vital information from the recipient handbooks and consent forms.

All written notices informing recipients of their right to interpretation and translation services in a language shall be translated when CRSA is aware that 1,000 or 5% (whichever is less) of CRSA's recipients speak that language and have LEP.

Oral interpretation services must be available and free of charge to all recipients regardless of the prevalence of the language. CRSA, and its subcontractors, must notify all recipients of their right to access oral interpretation services and how to access them [42 CFR 438.10(c)(4) and 438.10(c)(5)(i) and (ii)]. Refer to the AHCCCS Contractor Operations Manual, *CRS Recipient Information Policy*.

CRSA and its subcontractors shall make every effort to ensure that all information prepared for distribution to recipients is written at a 4th grade level. Regardless of the format chosen, the CRS recipient information must be printed in a type, style and size, which can easily be read by recipients with varying degrees of visual impairment. CRSA or its subcontractors must notify its recipients that alternative formats are available and how to access them [42 CFR 438.10(d)(1)(i) and (ii), 42 CFR 438.10(d)(2)].

CRSA or its subcontractors shall produce and provide the following printed information to each recipient or family within 10 days of receipt of notification of the enrollment date:

1. A recipient handbook, which, at a minimum, shall include the items, listed in the AHCCCS Contractor Operations Manual, *CRS Recipient Information Policy*.

CRSA or its subcontractors shall review and update the Recipient Handbook at least once a year. The handbook must be submitted to AHCCCS, DHCM for approval by September 1st of each contract year.

2. A description of CRSA or its subcontractor's provider network, which at a minimum, includes those items listed in the AHCCCS Contractor Operations Manual, *CRS Recipient Information Policy*.

CRSA or its subcontractors must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each recipient who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. Provider notices do not require prior approval.

CRSA must notify AHCCCS, Division of Health Care Management, of the material change in the provider network 15 days prior to the provider notice being sent out. During the 15 day time period, AHCCCS shall have the right to comment or may intervene if the change will lead to an adverse affect to the overall system.

A material change in CRSA policy or process requires 30 days advance notice to affected providers and recipients. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the recipients, providers, or AHCCCS programs, or may significantly impact the delivery of services provided by CRSA. CRSA shall require its subcontractors to submit the recipient notices to CRSA for review and approval. Affected recipients must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4)]. When there are program changes, notification shall be provided to the affected recipients at least 30 days before implementation.

CRSA or its subcontractors will, on an annual basis, inform all CRS recipients of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)]:

- a. An updated recipient handbook at no cost to the recipient; and,
- b. The network description as described in the ACOM *CRS Recipient Information Policy*.

This information may be sent in a separate written communication or included with other written information such as in a recipient newsletter.

10. TRANSITION OF RECIPIENTS

CRSA and AHCCCS shall coordinate policies and procedures to ensure compliance with AHCCCS medical policy about transitioning of recipients between CRSA subcontractors and a) AHCCCS health plans, b) ALTCS program contractors, or c) IHS/638 tribal entities upon discharge from a CRS clinic and/or discharge from the CRS program.

CRSA or its subcontractors shall coordinate a recipient's discharge from a hospital. CRSA shall advise the recipient's health plan/program contractor of the discharge and ensure coordination of the services with the health plan/program contractor.

CRSA, or its subcontractor, shall notify the recipient's health plan/program contractor to begin the coordination during the transition of care for the recipient, 30 days prior to termination of CRS eligibility,

or as soon as known if less than 30 days, as required in the *AMPM*, and the *ACOM, Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy*.

11. STAFF REQUIREMENTS AND SUPPORT SERVICES

CRSA shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, CRSA shall not employ or contract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

At a minimum, the following staff is required:

- a. A full time **Administrator/CEO/COO** who is available at all times to fulfill the responsibilities of the position and to oversee the entire operations. The Administrator shall devote sufficient time to CRSA's operations to ensure adherence to program requirements and timely responses to AHCCCS Administration. In the event that the Administrator/CEO/COO is unavailable, CRSA shall identify a staff member who has the authority to make administrative decisions regarding CRSA's operations to ensure adherence to program requirements and timely responses to AHCCCS Administration.
- b. A **Medical Director** who shall be an Arizona-licensed physician. The Medical Director shall be actively involved in all-major clinical programs and QM/UM components of CRSA as required in the *AMPM*. The Medical Director shall devote sufficient time to CRSA to ensure timely medical decisions, including after-hours consultations as needed.
- c. A **Quality Management/Utilization Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant.
- d. A **Chief Financial Officer** who is available at all times to fulfill the responsibilities of the position and to oversee the budget and accounting systems implemented by CRSA.
- e. A **Provider Services Coordinator** to coordinate communications between CRSA and its subcontractors. CRSA must have sufficient staff to enable its subcontractors to receive prompt resolution to their problems or inquiries and appropriate education about participating in the AHCCCS program.
- f. A **Grievance System Coordinator** who is responsible for oversight of CRSA grievance system for members and subcontractors.
- g. A **Compliance Officer** who is independent of the Administrator/CEO/COO and is responsible for implementing and overseeing CRSA's compliance program. The Compliance Officer shall be a senior, on-site official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCSA, Office of Program Integrity.
- h. A **Cultural Competency Coordinator** as noted in the AHCCCS Operations Manual, Cultural Competency Policy.
- i. A **Business Continuity and Recovery Coordinator** as noted in the ACOM Business Continuity and Recovery Policy.

By August 31st, CRSA shall submit to AHCCCS, Division of Health Care Management, CRSA's organizational chart that includes names of staff, position titles, staff member's resume, and a description of staff member's functions and time allocated to overseeing CRSA operations. CRSA shall inform AHCCCS, Division of Health Care Management, in writing within seven days when an employee leaves one of the key positions listed above. In the written notification, CRSA is required to name an "acting" or "interim" person for any vacated "key staff" position. The name and resume or summary of qualifications of the key staff

should be submitted as soon as the new hire has taken place. CRSA shall ensure that all staff have appropriate training, education, experience and orientation to fulfill the requirements of the position.

CRSA shall establish minimum staffing requirements for subcontractors. CRSA shall include these staffing requirements in contract.

12. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

CRSA shall develop, maintain and distribute written policies, procedures and job descriptions for each functional area of its program, consistent in format and style. CRSA shall ensure that each subcontractor is issued a copy of the policies. CRSA shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. CRSA shall review all policies and procedures at least annually to ensure that CRSA's written policies reflect current practices. Reviewed policies shall be dated and signed by the appropriate administrative staff. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the CRSA Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

CRSA shall provide AHCCCSA with a copy of the CRSA policy manual. Copies of final policies shall be submitted to AHCCCSA at least ten (10) working days prior to implementation. AHCCCSA shall receive updates on an as-revised basis. AHCCCSA shall distribute CRS policies to the health plans/program contractors when appropriate.

13. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT (QM/UM)

Quality Management (QM): CRSA or its subcontractors shall provide quality medical care to members, regardless of payer source or eligibility category. CRSA shall use and disclose medical records and any other health and enrollment information that identifies a particular member in accordance with Federal and State privacy requirements. CRSA shall execute processes to assess, plan, implement and evaluate quality management and performance improvement activities, as specified in the AMPM, that include at least the following:

1. Conducting Performance Improvement Projects (PIPs);
2. QM monitoring and evaluation activities;
3. Investigation, analysis, tracking and trending of quality of care issues, abuse and/or complaints;
 - a. Acknowledgement letter to the originator of the concern
 - b. Documentation of all steps utilized during the investigation and resolution process
 - c. Follow-up with the member to assist in ensuring immediate health care needs are met
 - d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns
 - e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern
4. AHCCCS mandated performance measures; and
5. Credentialing, recredentialing and provisional credentialing processes for provider and organizations.

AHCCCS has established a uniform credentialing, recredentialing and provisional credentialing policy. CRSA shall demonstrate that its providers are credentialed and:

- a. Shall follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with CRSA;
- b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and,
- c. Shall not employ or contract with providers excluded from participation in Federal health care programs.

CRSA shall submit, within timelines specified in ATTACHMENT B, a written QM plan that addresses its strategies for performance improvement and conducting the quality management activities described in this section. CRSA shall conduct performance improvement projects as required by the *AMPM*.

CRSA may combine its quality management plan with the plan that addresses utilization management as described below.

CRSA shall execute a process to assess, plan, implement and evaluate quality management activities, as specified in the *AMPM*, that include the Quarterly Quality Management Report.

Utilization Management (UM): CRSA shall execute processes to assess, plan, implement and evaluate utilization management activities, as specified in the *AMPM*, that include at least the following:

1. Pharmacy Management including the evaluation, reporting, analysis and interventions based on the data and reported through the UM Committee;
2. Prior authorization;
For the processing of requests for initial and continuing authorizations of services CRSA shall:
 - a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions [42 CFR 438.210(b)(2)];
 - b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
 - c. Comply with timely review of requests, including pended requests requiring further information. All decisions will comply with a twenty-eight day completion including any time the request has been with another provider;
 - d. Monitor and report on prior authorization timeliness; and,
 - e. Monitor and report on decisions, which result in denial, limited authorization or reduction in service and the notice of action provided to the member (or authorized representative) and the provider requesting the service
3. Develop and/or adoption of practice guidelines [42 CFR 438.236(b)] that:
 - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - b. Consider the needs of CRSA members;
 - c. Are adopted in consultation with contracting health care professionals;
 - d. Are disseminated by CRSA to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)];
 - e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply; and
 - f. Are reviewed and updated periodically within timeframes as appropriate.
4. Concurrent review;

- a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)];
 - b. Discharge planning
5. Continuity and coordination of care;
6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438.240(b)(3)];
7. Evaluation of new medical technologies, and new uses of existing technologies;
8. Quarterly Utilization Management Report (details in the *AMPM*).

CRSA shall have a process to report UM data and management activities through a UM Committee. CRSA's UM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. CRSA shall have in effect mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs. [42 CFR 438.240(b)(4)]

CRSA shall maintain a written UM plan that addresses its plan for monitoring UM activities described in this section. The plan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in ATTACHMENT B.

14. PERFORMANCE STANDARDS

Performance Standards [42 CFR 438.240(a)(2), (b)(2) and (c)]: All Performance Standards described below apply to all recipients. CRSA must meet AHCCCS stated Minimum Performance Standards. However, it is equally important that CRSA continually improve its performance indicator measure outcomes from year to year. CRSA shall strive to meet the goal established by AHCCCS.

Any statistically significant drop in CRSA's performance level for any measure must be explained by the CRSA in its annual quality management program evaluation. If CRSA has a significant drop in any measure without a justifiable explanation, it will be required to submit a corrective action plan and may be subject to sanctions.

AHCCCS has established two levels of performance:

Minimum Performance Standard – A Minimum Performance Standard is the minimally expected level of performance by CRSA. If CRSA does not achieve this standard, or the rate for any indicator declines to a level below the AHCCCS Minimum Performance Standard, CRSA will be required to submit a corrective action plan and may be subject to sanctions.

Goal – The Goal is the ultimate benchmark to be achieved. If CRSA has already achieved or exceeded the Minimum Performance Standard for any performance measure, CRSA must strive to meet the goal for that measure. If CRSA has achieved the Goal, it is expected to maintain this level of performance in future years.

CRSA must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions on CRSA if it does not meet the Minimum Performance Standard and does not show statistically significant improvement in any performance measure rate and/or require CRSA to demonstrate that it is allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan from CRSA if a statistically significant decrease in its rate is shown, even if it meets or exceeds the Minimum Performance Standard.

The corrective action plan must be received by AHCCCS within 30 days of receipt of notification from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up on-site reviews to verify compliance with a corrective action plan.

The following table identifies the Minimum Performance Standards and Goals for each Measure:

CRS Performance Measures

Performance Measure	Minimum Performance Standard	Goal
Preliminary Determination of Medical Eligibility	75%	90%
Timeliness of Initial Evaluation	75%	90%
First Appointment with CRS Specialty Provider	75%	90%

The Performance Measures are defined as follows:

Preliminary Determination of Medical Eligibility – The percent of AHCCCS members for whom:

- 1) A preliminary determination of medical eligibility was made and who were notified in writing of their scheduled initial clinic appointment date (to determine medical eligibility) within 10 business days of a complete CRS Referral Form* received by a CRS Regional Contractor;
- 2) A preliminary determination of medical eligibility could not be made because the CRS Referral Form received was incomplete and who were notified in writing within 10 business days of receipt of the Referral Form of the additional information that must be submitted in order for the CRS Regional Contractor to make a preliminary determination of medical eligibility; and,
- 3) A determination was made that the member was not medically eligible and who were notified in writing that their eligibility was denied within 10 business days of a complete CRS Referral Form* received by a CRS Regional Contractor.

* A complete CRS Referral Form is one that includes information in all the required fields to be submitted on the form, as specified in the CRS Policy and Procedure Manual, 20.400, *Preliminary Determination of Medical Eligibility*.

Denominator: All AHCCCS-enrolled children (age up to 21 years) referred to CRS during the measurement period.

Numerators:

- 1) All children in the denominator whose written notice of preliminary determination of medical eligibility (with a scheduled clinic appointment date) was mailed within 10 days of a complete CRS Referral Form received by a CRS Regional Contractor.
- 2) All children in the denominator whose written notice of additional information needed to make a preliminary determination of medical eligibility was mailed within 10 days of a CRS Referral Form received by a CRS Regional Contractor.
- 3) All children in the denominator whose written notice of denial for CRS eligibility was mailed within 10 days of a complete CRS Referral Form received by a CRS Regional Contractor.

Measurement Period: July 1, 2005, through June 30, 2006

Data Collection and Validation Process: AHCCCS will identify the denominator population (including, but not limited to, the member's AHCCCS ID number, name and date of birth). CRSA will collect numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). CRSA will provide the date the CRS Referral Form was received by the Regional Contractor, and indicate whether the Form was complete or incomplete, along with the date that CRS sent the first written notice regarding eligibility determination.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

Timeliness of Initial Evaluation – The percent of AHCCCS-enrolled members who were scheduled for an initial clinic appointment (evaluation) within 30 calendar days after a notice of preliminary determination of medical eligibility was mailed to the member or member's parent.

Denominator: All AHCCCS-enrolled children who were determined eligible for and enrolled in CRS during the measurement period.

Numerator: All children in the denominator whose initial medical evaluation appointment was scheduled for a date that was no more than 30 days after a notice of preliminary determination of medical eligibility was mailed by the CRS Regional Contractor.

Measurement Period: July 1, 2005, through June 30, 2006

Data Collection and Validation Process: AHCCCS will identify the denominator population (including, but not limited to, the member's AHCCCS ID number, name and date of birth). CRSA will collect numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). CRSA will provide the date for which the initial medical evaluation appointment was first scheduled following preliminary determination of medical eligibility and the date that the notice of preliminary determination of medical eligibility was mailed to the member or member's parent.

AHCCCS will identify a statistically significant random sample of recipients who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

First Appointment with CRS Specialty Provider – The number of AHCCCS members who are enrolled in CRS and are scheduled for their first specialty clinic visit within 45 calendar days of the CRS Regional Contractor making a positive determination of medical eligibility.

Denominator: All AHCCCS children enrolled in CRS during the measurement period.

Numerator: All children in the denominator who are scheduled for their first specialty clinic visit within 45 days of the CRS Regional Contractor making a positive determination of medical eligibility (enrollment date).

Measurement Period: July 1, 2005, through June 30, 2006

Data Collection and Validation Process: AHCCCS will identify the denominator population (including, but not limited to, the member's AHCCCS ID number, name and date of birth). CRSA will collect numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). CRSA will provide the date for which the specialty clinic appointment was first scheduled following determination of medical eligibility for and enrollment in CRS. AHCCCS may, as an alternate method of collecting data, identify specialty visits for members in the denominator from its encounter data.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

CRSA shall implement an ongoing quality assessment and performance improvement programs for the services it furnishes to members. Basic elements of the Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the following requirements:

Quality Assessment Program

CRSA shall have an ongoing quality assessment program for the services it furnishes to recipients that includes the following [42 CFR 438.240(a)(1)]:

1. The program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.
2. Annually CRSA shall:
 - a. If required, measure and report to the State its performance, using standard measures required by the State, or
 - b. Submit to the State, data specified by the State, that enables the State to measure CRSA's performance; or,
 - c. Perform a combination of the activities.
3. CRSA shall have in effect mechanisms to detect both underutilization and over utilization of services [42 CFR 438.240(b)(3)].
4. CRSA shall have in effect mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs [42 CFR 438.240(b)(4)].

Performance Improvement Program [42 CFR 43.240(b)(1), (d)(1)]

CRSA shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following [42 CFR 438.240(a)(1)]:

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions; and,
4. Planning and initiation of activities for increasing or sustaining improvement.

CRSA must submit the self selected proposed PIP methodology to AHCCCSA to review and approval by October 1st.

By July 1, 2005, CRSA will have implemented the following Performance Improvement Project (PIP):

Improving Pediatric to Adult Transition Services – This PIP will measure and implement activities to improve transition planning and services beginning at age 14 for AHCCCS members who are receiving services from CRS and will transition back to their Health Plans by age 21.

The AHCCCS-approved methodology for this PIP is included as Attachment F. CRSA will provide its baseline measurement to AHCCCS and implement interventions during CYE 2006.

CRSA must develop and submit a self-selected proposal to AHCCCSA for a new PIP to be implemented in CYE 2006.

CRSA shall report the status and results of each project to AHCCCSA as requested [42 CFR 438.240(d)(2)]. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year [42 CFR 438.240(d)(2)].

15. APPOINTMENT STANDARDS FOR CRS RECIPIENTS

CRSA and its subcontractors shall have procedures in place that ensure the following standards are met:

1. For a CRS recipient with a medically urgent need, the CRS recipient must be seen according to the needs of the member and no later than 72 hours of the request.
2. All other clinic appointments scheduled within 45 calendar days or less of referral, depending on the need of the CRS recipient's medical condition.

CRSA shall monitor its subcontractors for compliance with appointment standards and reduce the unnecessary use of emergency room services [42 CFR 438.206(c)(1)(i)]. CRSA shall monitor and ensure that a recipient's waiting time for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency.

If a health plan/program contractor is required to render any CRS covered service due to CRSA or its subcontractors' failure to meet medically necessary appointment standards, CRSA shall be financially responsible for those services as specified in the *AMPM*, Chapter 400, *Children's Rehabilitative Services Medically Necessary Appointment Policy*.

Missed appointments shall be rescheduled in a timely manner. In the event a recipient misses an appointment, CRSA shall ensure the appointment is rescheduled no later than 45 days unless medical judgment warrants an earlier appointment.

CRSA shall have written policies and procedure, which specify requirements for educating its provider network about appointment time requirements. CRSA shall require a corrective action plan when appointment standards are not met. CRSA shall be subject to sanction for failure to address problem clinics that do not meet appointment standards.

If a CRS recipient needs medically necessary non-emergency transportation, CRSA or CRSA subcontractors shall notify and coordinate with the health plan or program contractor to arrange transportation for AHCCCS members.

16. PROVIDER POLICY AND PROCEDURE MANUAL

CRSA or its subcontractors shall develop, distribute and maintain a policy and procedure manual as described below. CRSA shall ensure that each subcontractor is issued a copy of the policy and procedure manual and is encouraged to distribute a copy to any individual or group that submits claim and encounter data. CRSA shall be responsible for ensuring that all providers meet all applicable AHCCCS requirements including the provision of covered services and billing. At a minimum, CRSA or its subcontractors' policy and procedure manual must contain information on the following:

- a. Introduction to CRS, which explains CRS' organization and administrative structure
- b. Provider responsibility and CRS' expectations of the provider
- c. Listing and description of non-covered services, requirements and limitations
- d. CRSA's reporting requirements for providers to report to the recipient's PCP
- e. Grievance and appeal rights
- f. Billing and encounter submission information such as:
 1. Which form, UB92, HCFA 1500, or Form C is to be used for services
 2. Which fields are required for a claim to be considered acceptable by CRS
 3. A completed sample of each form
- g. Provider network address:
 1. Provider selection and retention criteria [42 CFR 438.241(a)]
 2. Credentialing and recredentialing of providers consistent with Chapter 900 of the AMPM [42 CFR 438.206(b)(1), (2), and (6)]
- h. Claims re-submission policy and procedure
- i. Reimbursement
- j. Explanation of remittance advice
- k. Prior authorization requirements
- l. Claims medical review
- m. Concurrent review
- n. Fraud and Abuse
- o. Appointment standards
- p. Coordination of services with AHCCCS health plan/program contractors
- q. Quality Management standards
- r. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist recipients who speak a language other than English or who use sign language.
- s. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable

This information may also be contained in the provider contract.

17. NETWORK DEVELOPMENT

CRSA shall develop and maintain a provider network that is supported by written agreements, which is sufficient to provide all CRS covered services to AHCCCS members [42 CFR 438.206(b)(1)]. It shall ensure covered services are provided promptly and are accessible in terms of location and hours of operation [42 CFR 438.206(c)(2)(ii)]. There shall be sufficient professional and paramedical personnel for the provision of CRS services.

If the network is unable to provide medically necessary services required under contract, CRSA or its subcontractors shall ensure timely and adequate coverage of these services through an out of network

provider until a network provider is contracted [42 CFR 438.206(b)(4)]. CRSA shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(5)]

CRSA or its subcontractors shall not discriminate with respect to participation in the CRS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)]. In addition, CRSA or its subcontractors must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit limiting provider participation to the extent necessary to meet the needs of CRS recipients. This provision also does not interfere with measures established by CRSA or its subcontractors to control costs consistent with its responsibilities under this contract nor does it preclude CRSA from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If CRSA or its subcontractors decline to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision [42 CFR 438.12(a)(1)]. CRSA or its subcontractors may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

Provider Network Development and Management Plan: CRSA or its subcontractors shall develop and maintain a provider network development and management plan, which ensures that the provision of CRSA covered services will occur as stated above [42 CFR 438.207(b)]. This plan shall be updated annually and submitted to AHCCCS, DHCM, 45 days from the start of each contract year. The submission of the network management and development plan to AHCCCSA is an assurance of the adequacy and sufficiency of CRSA's provider network. CRSA shall also submit as needed an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population. [42 CFR 438.207(c)] The plan shall identify the current status of the CRSA's network, and project future needs based upon, at a minimum, recipient growth; the number and types (in terms of training, experience and specialization) of providers that exist in CRS' service area, as well as the number of physicians who have privileges with and practice in hospitals; the expected utilization of services, given the characteristics of its population and its health care needs; the numbers of providers not accepting new Medicaid patients; and access of its recipients to specialty services as compared to the general population of the community. The plan, at a minimum, shall also include the following:

- a. A network inventory of CRSA subcontractors and their providers by facility, provider type, name and specialization;
- b. Current network gaps;
- c. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing;
- d. Interventions to fill network gaps and barriers to those interventions;
- e. Outcome measures/evaluation of interventions;
- f. Ongoing activities for network development;
- g. Coordination between internal departments;
- h. Coordination with outside organizations; and,
- i. Specialty populations.

Provider-CRS Recipient Communication: CRSA shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a CRS recipient who is his or her patient, for:

- a. The CRS recipient's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)];

- b. Any information the CRS recipient needs in order to decide among all relevant treatment options [42 CFR 438.102(a)(1)(ii)];
- c. The risks, benefits, and consequences of treatment or non-treatment; and [42 CFR 438.102(a)(1)(iii)],
- d. The CRS recipient's right to participate in decisions regarding his or her care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.102(a)(1)(iv)].

18. NETWORK MANAGEMENT

CRSA shall have policies and procedures in place that pertain to all service specifications described in the *CRSA' Children's Rehabilitative Services Policy and Procedure Manual*. In addition, CRSA shall have policies specifying how CRSA will [42 CFR 438.214(a)]:

- a. Communicate with the CRS network regarding contractual and/or program changes and requirements;
- b. Monitor and ensure network compliance with policies and rules of AHCCCSA and CRSA including compliance with policies and procedures related to the grievance process and ensuring the recipient's care is not compromised during the grievance process;
- c. Evaluate the quality of services delivered by the network;
- d. Provide or arrange for medically necessary covered services should the CRS network become temporarily insufficient;
- e. Monitor network capacity to ensure that there are sufficient providers to handle the volume and needs of CRS recipients. This includes the provision of care to CRS recipients with limited English proficiency; and,
- f. Ensure service accessibility, including monitoring appointment standards, and appointment waiting times.

CRSA shall maintain and monitor a network of providers that is supported by written agreements, which is sufficient to provide adequate access to all services covered under the contract [42 CFR 438.206(b)(1)]. In establishing and maintaining the network, CRSA must consider the following [42 CFR 438.206(b)(1)]:

- a. Anticipated number of CRS recipients;
- b. Expected utilization of services, considering recipient characteristics and health care needs;
- c. Number and types (in terms of training, experience and specialization) of providers required to provide the contracted services;
- d. Network providers who are not accepting new CRS recipients; and,
- e. The geographic location of providers and recipients, considering distance, travel time, the means of transportation used by CRS recipients and whether the location provides physical access for CRS recipients with disabilities.

All material changes in CRS' provider network must be approved in advance by AHCCCS, DHCM. A material change is defined as one, which affects, or can reasonably be foreseen to affect, CRS' ability to meet the performance and network standards as described in this contract. The DHCM must be notified of planned material changes in the provider network before the change process has begun, for example, before issuing a 60-day termination notice to a provider.

CRSA shall notify AHCCCS, DHCM, in writing within one working day of any unexpected changes that would impair its provider network. This notification shall include: (1) information about how the change

will affect the delivery of covered services, (2) CRS' plans for maintaining the quality of recipient care if the provider network change is likely to result in deficient delivery of covered services and (3) CRS' plan to address and resolve any network deficiencies. AHCCCSA will assess proposed changes in CRS' provider network for potential impact on recipients' health care and provide a written response to CRSA within 14 days of receipt of request. For emergency situations, AHCCCSA will expedite the approval process.

19. PROVIDER REGISTRATION

CRSA shall ensure that each of its subcontractors providing AHCCCS covered services is registered with AHCCCSA as an approved service provider and has a unique AHCCCS Provider ID Number. A Provider Participation Agreement must be signed with each provider who does not already have a current AHCCCS ID number. The original shall be forwarded to AHCCCSA. This provider registration process must be completed in order for CRSA to report services a subcontractor renders to CRS recipients.

20. PERIODIC REPORT REQUIREMENTS

AHCCCSA, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data, and other information from CRSA. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in this contract. Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242 (b)(2)]:

1. *Timeliness* - Reports or other required data shall be received on or before scheduled due dates.
2. *Accuracy* - Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and AHCCCS defined standards.
3. *Completeness* - All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. CRSA shall comply with all changes specified by AHCCCSA.

CRSA shall be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data will likely continue beyond the term of the contract due to the lag time in the filing of source documents by subcontractors.

In addition to its own reporting requirements, CRSA is also solely responsible under this contract for all subcontractor and provider reporting requirements as stated within this document as well as all other documents incorporated by reference. In cases where CRSA receives reports directly from subcontractors, CRSA shall be responsible for analyzing the information, verifying its accuracy (resolving discrepancies, if needed) and developing a summary report, if appropriate, prior to submitting the required information to AHCCCSA. CRSA shall monitor subcontractors, taking corrective action if needed, to ensure required reports are accurate, complete and submitted on time. CRSA is responsible for submitting to AHCCCSA during the term of this contract the periodic reports listed and described in detail in Attachment B, Periodic Reports.

21. FINANCIAL OPERATIONS

CRSA shall ensure that it and each subcontractor has a system to produce complete, timely, reliable and accurate financial records in accordance with contract requirements for financial reporting as specified in the CRSA Financial Reporting Guide. Each subcontractor shall design and implement its financial operations system to ensure compliance with Generally Accepted Accounting Principles. Each subcontractor shall also file with CRSA an annual (more frequently if required by CRSA) CMS approved disclosure statement and related party transactions statement. CRSA shall evaluate all such statements to ensure that they conform to CMS requirements and, through its periodic audit and review procedures, shall ensure that the statements are complete and accurate. CRSA shall take immediate corrective action upon discovery of any failure to meet contract requirements.

22. FINANCIAL VIABILITY STANDARDS/PERFORMANCE GUIDELINES

AHCCCSA has established the following financial viability standard/performance guidelines as applicable to CRSA and the subcontractors' financial performance. These guidelines are analyzed as part of AHCCCSA's due diligence in contract oversight. On a quarterly and annual basis, AHCCCSA will review, among other items, the following:

Measures	How Measured	Target	Data Source	Frequency of Calculation
<i>Balance Sheet Viability Ratios</i>				
Current Ratios	Current Assets Divided by Current Liabilities	Not less than 1.0	Financial Statements of contracted entity	Quarterly
<i>Income Statement Viability Ratios</i>				
Administrative Expenses to AHCCCS Revenues	Administrative Expenses as a percent of AHCCCS Revenues	Not more than 35% of AHCCCS Revenues	Financial Statement of Contracted Entity	Quarterly-Contract YTD

23. REQUESTS FOR INFORMATION

AHCCCSA may, at any time during the term of this contract, request financial or other information from CRSA. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of CRSA except as required by law. Upon receipt of such written requests for information, CRSA shall provide complete information as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself or subsequently agreed to by AHCCCS and CRSA.

24. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS Special Terms and Condition and the BBA requirements, AHCCCSA, or an independent external agent, will conduct Operational and Financial Reviews to ensure operational and

financial program compliance [42 CFR 438.240(e)(2)]. The reviews will identify areas where improvements are necessary and will make recommendations accordingly. AHCCCSA will monitor CRSA's progress towards implementing mandated programs and provide CRSA with technical assistance if necessary. CRSA shall comply with all other medical audit provisions as required by AHCCCS Rule R9-22-Article 5 and R9-31-Article 5.

The type and duration of the Operational and Financial Review will be solely at the discretion of AHCCCSA. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCSA will notify CRSA at least three weeks in advance of the date of the on-site review. In preparation for the on-site Operational and Financial Reviews, CRSA shall cooperate fully with AHCCCSA and the AHCCCSA Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, logs and other information that AHCCCSA may request. CRSA shall have all requested medical records on-site. Any documents not requested in advance by AHCCCSA shall be made available upon request of the Review Team during the course of the review. CRSA personnel as identified in advance shall be available to the Review Team at all times during AHCCCSA on-site review activities. While on-site, CRSA shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

AHCCCSA shall provide a copy of the Operational and Financial Review Report to CRSA and CRSA will be given an opportunity to comment on any review findings prior to AHCCCSA publishing the final report. Recommendations made by the Review Team to bring CRSA into compliance with Federal, State and AHCCCS requirements must be implemented by CRSA. AHCCCSA may conduct a follow-up Operational and Financial Review to determine CRSA's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial Operational and Financial Review.

25. CLAIMS PAYMENT AND HEALTH INFORMATION SYSTEM

CRSA shall require CRSA subcontractors to develop and maintain claims payment systems capable of processing, cost-avoiding and paying claims in accordance with A.R.S. § 36-2903 and Article 7 of the AHCCCS rules, a copy of which may be found in the Bidder's Library.

The subcontractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of \$50,000 per provider within a contract year must be approved in advance by AHCCCSA, Division of Health Care Management. If AHCCCSA does not respond within 30 days, the recoupment request is deemed approved. AHCCCSA must be notified of any cumulative recoupment greater than \$50,000 per provider per contract year. A subcontractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim, without prior approval from AHCCCSA, unless the recoupment is a result of fraud, reinsurance audit findings, data validation or audits conducted by the AHCCCSA, Office of Program Integrity.

The subcontractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

In accordance with the Balanced Budget Act of 1997, CRSA shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a shorter time period is specified in contract, the subcontractor shall not pay a

claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the subcontractor's specified claim mailing address. The paid date of the claim is the date on the check or other form of payment. [42 CFR 447.45(d)] Claims submission deadlines shall be calculated from the date of service or the effective date of eligibility posting, whichever is later. Remittance advices accompanying the subcontractor's payments to providers must contain, at a minimum, adequate descriptions of all denials and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and provider rights for claim dispute.

For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 2903.01. When interest is paid, the subcontractor must report the interest separately from the health plan paid amount on the encounter. Interest should be reported in the 837 CAS adjustment loop using reason code "85".

CRSA subcontractors are required to accept HIPAA compliant electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. In addition, subcontractors shall implement and meet the following milestone in order to make claims processing and payment more efficient and timely:

- a. Subcontractors must be able to make claims payments via electronic Funds Transfer by June 30, 2006.
- b. Subcontractors are required to receive and pay 25% of all claims (based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs)) electronically by June 30, 2006.

The subcontractor shall develop and maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes and appeals. [42 CFR 438.242(a)]

The subcontractor will ensure that changing or making major upgrades to the information systems effecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least six months before the anticipated implementation date, the subcontractor shall provide the system change plan to AHCCCSA for review and comment.

26. COMPENSATION

Capitation Payments: AHCCCSA will pay CRSA a per recipient per month capitation rate for all prospective recipient months as determined by AHCCCSA, including partial recipient months. AHCCCSA will make monthly capitation payments to CRSA for each CRS recipient on the first of the month based on the previous month's AHCCCS/CRS recipient count. Payment shall be made not later than the end of the month for the previous month for which payment is due.

After the close of the final month of the state fiscal year (June 30), reconciliation will be made for the final month's recipient months adjusted by the payments made during the first month of the contract.

CRSA will be paid either a high, medium, or low capitation rate per region, pursuant to the CRS recipient's classification of region-specific high, medium, or low risk as defined by CRSA. Capitation rates represent the cost of providing covered CRS services to the CRS recipient. The capitation received

by CRSA shall represent payment in full for any and all covered services provided to the recipient, including the CRSA regional subcontractor administrative costs.

All funds received by CRSA and its subcontractors pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles and procedures.

An error discovered by the State with or without an audit in the amount of fees paid to CRSA will be subject to adjustment or repayment by CRSA by making a corresponding decrease in a current payment or by making an additional payment by AHCCCSA to CRSA.

Payments made by AHCCCSA to CRSA are conditioned upon the receipt by AHCCCSA of applicable, accurate and complete reports required to be submitted by CRSA under this contract.

Requests for Federal financial participation (FFP) from CRSA, and the pass through of Title XIX and Title XXI funds to CRSA from AHCCCSA, shall both adhere to the mandatory Cash Management Improvement Act (CMIA) of 1990 as established by the General Accounting Office of the Arizona Department of Administration (GAO/ADOA).

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or S-Chip, except for emergency services (Section 1932(d)(4) of the Social Security Act).

Establishment of Intergovernmental Agreement (IGA) Fund: CRSA shall, on an annual basis, transfer to AHCCCSA the total amount appropriated for the state match for Title XIX AHCCCS expenditures. This transfer shall be made, in its entirety, prior to the first Title XIX disbursement. . If CRSA is unable to roll forward its entire fiscal year allotment prior to the due date of the first Title XIX disbursement, AHCCCS will accept the receipt of the first quarter's allotment for the first capitation payment. However, the remainder of the annual state match requirement must be received before subsequent payments are made. AHCCCSA shall deposit the monies transferred into an IGA Fund of which AHCCCSA shall have sole disbursement authority.

When AHCCCSA draws FFP for qualifying CRSA disbursements, AHCCCSA will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to CRSA. AHCCCSA shall only draw FFP when sufficient state match funds are available. If AHCCCSA determines that additional monies are required, AHCCCSA shall notify CRSA that additional monies must be deposited into the IGA Fund prior to making additional Title XIX disbursements.

If at the end of a fiscal year, and after the close of any administrative adjustment period as defined in ARS 35-190-191, monies remain in the IGA Fund, AHCCCSA shall notify CRSA and transfer these monies back to CRSA. If it is determined that excessive funds exist in the IGA Fund, CRSA may request a withdrawal of monies prior to the end of the state fiscal year and/or prior to the close of the administrative adjustment period.

Capitation Rates: CRSA shall provide AHCCCSA with documentation relevant to the capitation rate calculation and is responsible for developing proposed, actuarially sound capitation rates to be paid by AHCCCSA for Title XIX and Title XXI members. CRSA must submit proposed capitation rates and supporting documentation, including the diagnostic classification of region-specific cost and risk levels, to AHCCCSA no later than April 1 of each year, or earlier if necessary to adhere to Federal capitation rate submission guidelines. If AHCCCSA does not receive a proposal and supporting documentation for

updating capitation rates from CRSA, AHCCCSA will use available information to update the rates or, if sufficient data is not available, will maintain rates at existing levels. Neither CRSA nor AHCCCS will consider costs of non-covered services in the development of capitation rates. [42 CFR 438.6(e)]

CRSA Administrative Cost Report: CRSA shall provide AHCCCSA with a report that details administrative expenditures by CRSA on a semi-annual basis. The format is to be determined.

Liability for Payment: CRSA must ensure that CRS recipients are not held liable for:

- a. CRSA or subcontractor's debts in the event of CRSA's or the subcontractor's insolvency;
- b. Covered services provided to the CRS recipient, for which AHCCCS does not pay CRSA and CRSA does not pay subcontractors; or,
- c. Payments to CRSA or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the CRS recipient would owe if CRSA or the subcontractor provided the services directly.

27. CAPITATION RECOUPMENT

Any recoupments imposed by the Federal government and passed through to CRSA shall be reimbursed to AHCCCSA upon demand.

28. BUDGET CAP

AHCCCSA will not be responsible for costs incurred by CRSA that exceed the budget cap associated with its legislative appropriation.

29. TERMS OF AUTHORIZATION

Federal funds provided under the annual authorization addressed above shall be available for the term defined in the annual authorization. If at any time during the term of this contract CRSA determines that the funding authorization is insufficient, CRSA shall notify AHCCCSA in writing and shall include in the notice recommendations as to resolution of the shortage.

30. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

Pursuant to federal and state law, AHCCCS is the payer of last resort. This means AHCCCSA shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. CRSA shall coordinate benefits in accordance with 42 CFR 433.135 et. seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et. seq. so that costs for services otherwise payable by CRSA are cost avoided or recovered from a liable first or third-party payer. CRSA may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

AHCCCS shall require all AHCCCS members with a CRS eligible medical condition, without private insurance, to enroll with CRS. For those members with a CRS eligible condition, with private insurance, enrollment with CRS shall be optional. Members with private insurance choosing not to enroll with CRS

may seek the payment of applicable copays and deductibles from the health plan/program contractor with whom they are enrolled. When the private insurance is exhausted with respect to CRS covered conditions, the health plan/program contractor is required to refer the member to CRSA for determination for CRS services. For those members with private insurance who are enrolled in the CRS program, CRSA or its subcontractor is responsible for applicable copays and deductibles related to the CRS condition.

The two methods used in the coordination of benefits are cost avoidance and post-payment recovery. CRSA shall use these methods as described in A.A.C. R9-22-1001 et. seq. and federal and state law. See Section D, Paragraph 31, Medicare Services and Cost Sharing.

Cost Avoidance: CRSA shall take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services. CRSA shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, CRSA must process the claims.

If a third-party insurer (other than Medicare) requires the CRS recipients to pay any copayment, coinsurance or deductible, CRSA is responsible for making these payments, even if the services are provided outside of the CRSA network. CRSA is not responsible for paying coinsurance and deductibles that are in excess of what CRSA would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS FFS payment equivalent. (CRSA must decide whether it is more cost-effective to provide the service within its network or pay coinsurance and deductibles for a service outside its network. For continuity of care, CRSA may also choose to provide the service within its network.) If CRSA refers the recipient for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance of all copayments, coinsurance and deductibles, CRSA must make such payments in advance.

If CRSA knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), CRSA shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. CRSA shall communicate any known change in health insurance information, including Medicare, to AHCCCS Administration, Division of Member Services, no later than 10 days from the date of discovery using the approved AHCCCS correspondence. If CRSA does not know whether a particular service is covered by the third party, and the service is medically necessary, CRSA shall contact the third party and determine whether or not such service is covered rather than requiring the recipient to do so. In the event that the service is not covered by the third party, CRSA shall arrange for the timely provision of the service. (See also Section D, Paragraph 31, Medicare Services and Cost Sharing.)

The requirement to cost-avoid applies to all AHCCCS covered services. In emergencies, CRSA shall provide the necessary services and then coordinate payment with the third-party payer. Further, if a service is medically necessary, CRSA shall ensure that its cost avoidance efforts do not prevent a recipient from receiving such service and that the recipient shall not be required to pay any coinsurance or deductibles for use of the other insurer's providers.

Postpayment Recoveries: Postpayment recovery is necessary in cases where CRSA was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost-avoid.

CRSA may retain up to one hundred percent (100%) of its third-party collections if all of the following conditions exist:

- a. Total collections received do not exceed the total amount of CRSA financial liability for the recipient;
- b. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e., lien filing, etc.); and,
- c. Such recovery is not prohibited by state or federal law.

CRSA shall identify all potentially liable third parties and pursue reimbursement from them except CRSA shall not pursue reimbursement in the following circumstances unless the case has been referred to CRSA by AHCCCSA or AHCCCSA's authorized representative:

- a. Uninsured/ underinsured motorist insurance;
- b. First and third party liability insurance;
- c. Tortfeasors, including casualty;
- d. Restitution recovery;
- e. Worker's compensation;
- f. Estate recovery; and,
- g. Special treatment trust recovery.

CRSA shall report to AHCCCSA's authorized representative all cases for which:

- a. Post-payment recovery is pursued by CRSA; and,
- b. CRSA identifies circumstances a. through g. above.

CRSA shall cooperate with AHCCCSA's authorized representative in all collection efforts.

Reporting: CRSA may be required to report case level detail of third-party collections and cost avoidance including number of referrals on total plan cases. CRSA shall communicate any known change in or addition to health insurance information, including Medicare, to AHCCCSA, Division of Member Services (DMS), not later than 10 days from the date of discovery using AHCCCS Approved Third-Party Correspondence.

31. MEDICARE SERVICES AND COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligible". Generally, Contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. CRSA is responsible for adhering to the cost sharing responsibilities presented in the *AHCCCS Medicare Cost Sharing Policy*. CRSA shall have no cost sharing obligation if the Medicare payment exceeds what CRSA would have paid for the same service of a non-Medicare member.

32. COPAYMENTS

Most of the AHCCCS members remain exempt from copayments while others are subject to an optional copayment. Those populations exempt or subject to optional copayments may not be denied services for the inability to pay the copayment [42 CFR 438.108].

Attachment D provides detail of the populations and their related copayment structure.

33. RECORDS RETENTION

CRSA shall maintain books and records relating to covered services and expenditures including reports to AHCCCSA and working papers used in the preparation of reports to AHCCCSA. CRSA shall comply with all specifications for record keeping established by AHCCCSA. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include, but not be limited to, financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCSA.

CRSA agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in paragraphs a. and b. below any of its records for inspection, audit or reproduction by any authorized representative of AHCCCSA, State or Federal government.

CRSA shall preserve and make available all records for a period of five years from the date of final payment under this contract. HIPAA related documents must be retained for a period of six years per 45 CFR 164.230(j).

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, appeals, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCSA, shall be retained by CRSA for a period of five years after the date of final disposition or resolution thereof.

34. MEDICAL RECORDS

The recipient's medical record is the property of the provider who generates the record. Each recipient is entitled to one copy of his or her medical record free of charge. CRSA shall have written policies and procedures to ensure the confidentiality of all medical records.

CRSA shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

CRSA shall have written standards for documentation on the medical record for legibility, accuracy and plan of care which comply with the *AMPM*. AHCCCSA or its designee may inspect such records at any time during regular business hours at the offices of CRSA, subcontractors, at hospitals or other service providers.

CRSA shall have written plans for training and for evaluation of CRSA subcontractors' compliance with CRSA's medical record standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

AHCCCSA is not required to obtain written approval from a recipient before requesting the recipient's medical record. CRSA may obtain a copy of a recipient's medical records without written approval of the recipient if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCSA shall be afforded access to all recipients' medical records whether electronic or paper within 20 working days of receipt of request.

Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed in accordance with ARS §36-664(I).

35. DATA EXCHANGE REQUIREMENTS

CRSA is authorized to exchange data with AHCCCSA relating to the information requirements of this contract and as required to support the data elements to be provided AHCCCSA in the formats prescribed by AHCCCSA and in formats prescribed by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the *HIPAA Transaction Companion Documents & Trading Partner Agreements*, and in the *AHCCCS Technical Interface Guidelines*, available in the Bidder's Library.

The information so recorded and submitted to AHCCCSA shall comply with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following appropriate notification to AHCCCSA.

CRSA is responsible for any incorrect data, delayed submission or payment (to CRSA or by CRSA to its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CRS-submitted data. Any data that does not meet the standards required by AHCCCSA shall not be accepted by AHCCCSA. CRSA shall not be responsible for any incorrect data or delays caused by AHCCCSA.

CRSA is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCSA. If any unreported inconsistencies are subsequently discovered, CRSA shall be responsible for the necessary adjustments to correct its records at its own expense.

CRSA shall accept from AHCCCSA original evidence of eligibility and enrollment in a form appropriate for electronic data exchange. Upon request by AHCCCSA, CRSA shall provide to AHCCCSA updated date-sensitive regional clinic assignments in a form appropriate for electronic data exchange.

AHCCCSA shall provide CRSA a subcontractor-specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by CRSA shall include the CRSA security code. By use of its security code, CRSA certifies that any data transmitted is accurate and truthful, to the best of the CRSA Administrator/CEO/COO or designee's knowledge [42 CFR 438.606]. Both parties agree to indemnify and hold harmless each other from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by their submitted data. AHCCCSA shall not be responsible for any incorrect or delayed payment by CRSA to its AHCCCS services providers (contractors) resulting from such error, omission, deletion, or erroneous input data caused by CRSA in the submission of AHCCCS claims.

The costs of software changes are included in administrative costs paid to CRSA. There is no separate payment for software changes. A PMMIS systems contact will be assigned after the contract has been signed. AHCCCSA will work with CRSA as they evaluate Electronic Data Interchange options.

On an annual basis by March of each year, AHCCCS shall provide to CRSA for public health purposes, an electronic summary of encounters, detailed by member, for all services received by CRS recipients who are enrolled in AHCCCS. Six months after the file is received, CRSA shall provide to AHCCCSA a report summarizing the results and/or conclusions drawn from the analysis of this data and any actions taken.

Health Insurance Portability and Accountability Act (HIPAA): CRSA shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of CRSA by the dates required by the implementing Federal regulations.

36. ENCOUNTER DATA REPORTING

The accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCSA uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. CRSA shall submit encounter data to AHCCCSA for all services for which CRSA incurred a financial liability and claims for services eligible for processing by CRSA where no financial liability was incurred, including services provided during prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)].

CRSA shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCSA. Upon submission, CRSA certifies that the services listed were actually rendered [42 CFR 455.1(a)(2)]. The encounters must be submitted in the format prescribed by AHCCCSA.

Encounter data must be provided to AHCCCSA by electronic media and must be submitted in the PMMIS AHCCCSA-supplied formats. Formatting and specific requirements for encounter data are described in the *AHCCCS Encounter Reporting User Manual* and the *AHCCCS Technical Interface Guidelines*, copies of which may be found in the Bidder's Library. The *Encounter Submission Requirements* are included herein as Attachment E.

An Encounter Submission Tracking Report must be maintained and made available to AHCCCSA upon request. The Tracking Report's purpose is to link each claim to an adjudicated or pended encounter returned to CRSA. Further information regarding the Encounter Submission Tracking Report may be found in *The Encounter User's Manual*.

37. RECIPIENT ROSTER RECONCILIATION

Recipient Roster: CRSA shall transmit, no less than monthly, via electronic transfer the names of recipients currently CRS eligible, or were CRS eligible at any time in the last six months, for which CRS provides covered services. CRSA shall screen individuals who are added to verify that they are eligible. This automated notification process shall include the following information:

- a. Information to identify the recipient;
- b. Effective dates for covered services; and,

- c. CRSA subcontractor to which the recipient is assigned and the assigned risk level.

38. TERM OF CONTRACT

The initial term of this Contract shall be upon signature of both parties through June 30, 2006. This contract shall be renewed on an annual basis. All contract extensions shall be through amendment.

39. CRSA SUBCONTRACTS

CRSA shall be legally responsible for performance of the terms of this contract whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c)]. No CRSA subcontract shall operate to limit the legal responsibility of CRSA to ensure that all activities carried out by the CRSA subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by CRSA pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(L)]. See the ACOM *Contractor Claims Processing by Subcontracted Providers* policy

All subcontracts entered into by CRSA for the provision of AHCCCS covered CRS services are subject to prior review and approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the terms and conditions of this contract. The following CRSA subcontracts shall be submitted to AHCCCS, Division of Health Care Management, for prior approval at least 30 days prior to the beginning date of the contract:

- a. Automated data processing
- b. Third-party administrators
- c. Management Services (See also Section D, Paragraph 43)
- d. Subcontracts for CRS clinic services

CRSA shall maintain a fully executed original of all CRSA subcontracts, related to AHCCCS covered services, which shall be accessible to AHCCCSA within two working days of request by AHCCCSA. All requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of CRSA except as required by law. As it pertains to AHCCCS members and services, a CRSA subcontract is voidable and subject to immediate cancellation by AHCCCSA in the event any CRSA subcontract referenced above is implemented without the prior written approval of AHCCCSA. All CRSA subcontracts related to AHCCCS covered services shall comply with the applicable provisions of Federal and State laws, regulations and policies.

CRSA and/or the subcontractors shall not contract or subcontract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549. [42 CFR 438.610(a), and (b)] Due to security and identity protection concerns, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers. CRSA must timely submit final, signed copies of each contract which it enters into with subcontractors and Tribal subcontractors and any subsequent amendments. CRSA shall require that

copies of executed contracts between a subcontractor and service provider shall be made available within five days of a request by AHCCCS. It is CRSA's responsibility to prepare and distribute to all interested parties upon request the subcontractors contract amendments resulting from federal or state legislative changes or changes in the terms of this contract and to ensure that subsequent provider subcontract amendments are completed in a timely manner.

If CRSA delegates duties or responsibilities to a subcontractor, then CRSA shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. [42 CFR 438.230(b)(2)] The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. [42 CFR 438.230(b)(2)] In order to determine adequate performance, CRSA shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by AHCCCSA [42 CFR 438.230(b)(3)]. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)(4)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion [42 CFR 438.230(b)(3)].

CRSA shall not include covenant-not-to-compete requirements in its subcontracts. Specifically, CRSA shall not contract with a provider and require that the provider not provide services for any other AHCCCS contractor.

CRSA shall ensure that compensation to entities that conduct utilization management activities is not structured so as to provide incentives for the subcontractor or provider to deny, limit, or discontinue medically necessary services to any CRS recipient. [42 CFR 438.210(e)]

Each CRSA subcontract must contain verbatim all the provisions of Attachment A, Minimum Subcontract Provisions. In addition, each CRSA contract must contain the following [42 CFR 438.206(b)(1)]:

- a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
- b. Identification of the name and address of the subcontractor.
- c. Identification of the population, to include patient capacity, to be covered by the subcontractor.
- d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
- e. The term of the contract including beginning and ending dates, methods of extension, termination and renegotiation.
- f. The specific duties of the subcontractor relating to coordination of benefits and determination of third party liability.
- g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to CRSA.
- h. A description of the subcontractor's patient, medical and cost record keeping system.
- i. Specification that the subcontractor shall cooperate with quality improvement programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the *AMPM*.
- j. A provision stating that a merger, reorganization or change in ownership of a subcontractor that is related to or affiliated with CRSA shall require a contract amendment and prior approval of AHCCCSA.
- k. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this

subcontract, for itself and its employees, and that AHCCCSA shall have no responsibility or liability for any such taxes or insurance coverage.

- l. A provision that the subcontractor must obtain any necessary authorization from CRSA for services provided to CRS eligible individuals and/or CRS recipients.
- m. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
- n. A provision that the subcontractors must submit standardized, detailed financial statements on a quarterly and annual basis to CRSA. Clinic subcontractors must have an annual financial audit conducted by an independent CPA.
- o. A provision that emergency services do not need prior authorization and that, in utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a “prudent layperson” is defined as a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interest and the interests of others. The phrase does not apply to a person’s ability to reason, but rather the prudence with which he acts under a given set of circumstances.
- p. A provision that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individuals or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

40. SUBCONTRACTOR COMPLIANCE WITH CONTRACT REQUIREMENTS [42 CFR 438.6(l)]

CRSA shall be held fully liable for the performance of all contract requirements contained herein and shall develop and maintain a system for regular and periodic assessment of all subcontractors’ compliance with its terms [42 CFR 438.230(a) and 434.6(c)]. CRSA shall advise AHCCCSA in writing within five working days of any subcontractor non-compliance and of the corrective measures taken, including the amount and duration of sanctions, to ensure subsequent compliance [42 CFR 438.230(b)(4)].

CRSA shall include provisions in its subcontracts that allow it to suspend, deny, refuse to renew, or terminate any subcontracts in accordance with the terms of this contract and applicable law and regulations. CRSA may, in addition to these remedies, impose financial sanctions on subcontractors for failure to perform as required, failure to submit timely and accurate reports, engaging in actions which jeopardize Federal Financial Participation or for any other breach of the terms of this contract [42 CFR 438.230(b)(2)]. Written notice must be provided to the subcontractor specifying the grounds for sanction, the amount of funds to be withheld from capitation payments and steps necessary to avoid future sanctions. Other sanctions may be imposed against the subcontractors and their service providers in accordance with defined CRSA policies.

41. CAPITALIZATION REQUIREMENTS FOR SUBCONTRACTORS

Minimum capitalization requirements for subcontractors shall be specified in all Requests For Proposals issued by CRSA to solicit offers from entities, other than direct providers.

All subcontracts shall include terms necessary to ensure subcontractor financial stability and adequate performance. These terms shall include the maintenance of deposits, performance bonds, financial reserves or other financial security. In lieu of a performance bond or other security requirement, CRSA may, at its discretion, accept evidence that a subcontractor has posted other security, equal to or greater than that required by CRSA, with a State agency for the performance of health service contracts. The

funds from such other security must be available to CRSA upon default or nonperformance by the subcontractor.

42. CRSA'S RIGHT TO OPERATE SUBCONTRACTOR

All subcontracts shall include terms describing the circumstances under which CRSA would be authorized to step in and operate the subcontractor directly. Where warranted, CRSA shall, after delivering appropriate notice to the deficient subcontractor, operate the subcontractor for only so long as it is necessary to assure delivery of uninterrupted care to recipients, transition the recipients to a new subcontractor, or until the deficient subcontractor corrects all deficiencies.

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

All proposed management services subcontracts and/or cost allocation plans must be approved in advance by AHCCCSA, Division of Health Care Management, as described in Section D, Paragraph 37, CRSA Subcontracts. Cost allocation plans must be submitted with the proposed management fee agreement. AHCCCSA reserves the right to perform a thorough review of actual management fees charged and/or allocations made. If the fees or allocations actually paid out are determined to be unjustified or excessive, amounts may be subject to repayment to CRSA, CRSA may be placed on monthly financial reporting, and/or financial sanctions may be imposed.

44. RESERVED

45. SANCTIONS

AHCCCSA may suspend, deny, refuse to renew, or terminate this contract or any AHCCCS related CRSA subcontracts in accordance with AHCCCS Rule R9-22-606, ACOM, *Sanctions Policy*, the terms of this contract and applicable Federal or State law and regulations. [42 CFR 422.208, 42 CFR 438.700, 702, 704, and 45 CFR 92.36(i)(1)] AHCCCSA may, in addition to these remedies, impose monetary sanctions if CRSA violates any provision stated in law or this contract in accordance with AHCCCS Rule R9-22-606 and the provisions of this contract, applicable law and regulations. Written notice will be provided to CRSA specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of sanction. AHCCCS will prepare the AHCCCS side of the (GAO-6-4 transfer documents and forward them to CRSA to complete its side of the transactions. One transfer will reduce the Federal Share of the capitation payment and the second transfer document is intended for CRSA to account for their state match sanction expenditure funded by a state match source chosen by CRSA. A copy of the transfer document will be sent with the monthly capitation payment to notify CRSA that the sanction has taken place. CRSA may appeal the decision to impose a sanction in accordance with AHCCCS Rule R9-22-604. Intermediate sanctions may be imposed for, but not limited to, the following actions:

- a. Substantial failure to provide medically necessary services that CRSA is required to provide under the terms of this contract.
- b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
- c. Discrimination among CRS recipients on the basis of their health status of need for health care services.

- d. Misrepresentation or falsification of information furnished to CMS or AHCCCSA.
- e. Misrepresentation or falsification of information furnished to a recipient, potential recipient, or provider.
- f. Failure to meet AHCCCS Financial Viability Standards.
- g. Material deficiencies in CRS provider network.
- h. Failure to meet quality of care and quality management requirements.
- i. Failure to meet AHCCCS encounter standards.
- j. Violation of other applicable State or Federal laws or regulations.
- k. Failure to require subcontractors to increase the Performance Bond in a timely manner.
- l. Failure to comply with any provisions contained in this contract.
- m. Failure to report third party liability cases as described in paragraph 30.

AHCCCSA may impose the following types of intermediate sanctions:

- a. Civil monetary penalties.
- b. Appointment of temporary management for CRSA as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M).
- c. Suspension of payment for recipients after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- d. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process: Prior to the imposition of a sanction for non-compliance, AHCCCSA may provide a written cure notice to CRSA regarding the details of the non-compliance. The cure notice will specify the period of time during which CRSA must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, CRSA has complied with the cure notice requirements, AHCCCSA will take no further action. If, however, CRSA has not complied with the cure notice requirements, AHCCCSA will proceed with the imposition of sanctions. Refer to the ACOM *Sanctions Policy* for details.

The Administration shall impose on CRSA any financial penalties or disallowances imposed on the State by the Federal government related to CRSA's performance under this Agreement. The imposition of these sanctions upon CRSA shall not be levied until such time as the Federal government shall have actually imposed sanctions upon the State for conduct related to CRSA's performance under this Agreement. The Administration shall confer with CRSA concerning defenses or objections to the imposition of such sanctions at all stages of the sanction process. In the event that the Federal government imposes sanctions upon the state, CRSA shall reimburse the Administration upon demand, or the Administration will process a transfer (GAO-614) document, any such sanction or disallowance amount or any amount determined by the Federal government to be unallowable, after exhaustion of the appeals process (if Federal regulations so permit) as long as the Federal government does not levy the sanctions until after the appeals process is completed. CRSA shall bear the administrative cost of such an appeals process.

46. GRIEVANCE SYSTEM

CRSA shall have in place a written grievance system for subcontractors, CRS recipients and providers, which defines their rights regarding disputed matters with the CRSA. CRSA's grievance system for recipients includes a grievance process (the procedures for addressing recipient grievances), an appeals process and access to the State's fair hearing process. CRSA shall provide the appropriate personnel to establish, implement and maintain the necessary functions related to the grievance systems process. Refer to

Attachments C(1) and C(2) for *CRS Recipient Grievance System and Provider Grievance System Standards and Policy*, respectively.

CRSA may delegate the grievance system process to subcontractors, however, CRSA must ensure that standards which are delegated comply with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. CRSA shall remain responsible for compliance with all requirements. CRSA shall also ensure that it timely provides written information to both CRS recipients and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a State fair hearing, a method for obtaining a state fair hearing, the rules that govern representation at the hearing, the right to file grievance, appeals, and claim dispute the requirements and timeframes for filing grievance, appeals and claim dispute, the availability of assistance in the filing process, the toll-free numbers that the CRS recipient can use to file a grievance or appeal by phone, that benefits will continue when requested by the CRS recipient in an appeal or State fair hearing request concerning certain action which are timely filed, that the CRS recipient may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the CRS recipient, and that a provider may file an appeal on behalf of an CRS recipient with the CRS recipient's written consent. Information to CRS recipients must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 9, Recipient Information, and Paragraph 48, Cultural Competency.

CRSA shall be responsible to provide the necessary professional, paraprofessional and clerical services for the representation of CRSA in all issues relating to the grievance system and any other matters arising under this contract which rise to the level of administrative hearing or a judicial proceeding. Unless there is an agreement with the State in advance, CRSA or its subcontractors shall be responsible for all attorney fees and costs awarded in a judicial proceeding.

47. QUARTERLY GRIEVANCE SYSTEM REPORTS

Appeal and Claim Dispute Report: CRSA must submit the AHCCCS Quarterly Appeal and Claim Dispute Report to AHCCCS, Division of Health Care Management (DHCM), using the AHCCCS Quarterly Appeal and Claim Dispute Report Format on file in the Bidder's Library. The Quarterly Grievance Report must be received by the AHCCCS, DHCM, no later than 45 days from the end of the quarter.

Recipient Grievance Report: CRSA and its subcontractors must accept, resolve and track recipient grievances as required in the *ACOM Enrollee Grievance Policy*. CRSA must submit the Recipient Grievance Report no later than 45 days from the end of each quarter. The report must include the following:

- A. Number of grievances received in the reporting period
 - i. Total
 - ii. By the categories used in the CRSA's executive summary reports
- B. Number of days to resolution
 - i. Number resolved within 10 days
 - ii. Number resolved in 11 or more days, but less than 20 days
 - iii. Number resolved in 30 or more days, but less than 59 days
 - iv. Number resolved in 60 to 90 days
 - v. Average days to resolution

Report A. and B. above by the current quarter, prior quarter and current quarter for the previous year.

CRSA shall trend and analyze grievance, appeals and claim dispute at least quarterly and any identified trends and corrective action plans should be reported to AHCCCSA, Division of Health Care Management.

48. CULTURAL COMPETENCY

CRSA shall have a Cultural Competency Plan that meets the requirements of the AHCCCS Operations Manual *Cultural Competency Policy*. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the DHCM no later than 45 days after the start of each contract year. CRSA must identify a staff member responsible for the cultural competency plan and inform the DHCM of that person's identity.

49. MEDICAID SCHOOL BASED CLAIMING (SBC)

Pursuant to an Intergovernmental Agreement with the Department of Education, and a contract with a Third Party Administrator, AHCCCS pays participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the recipient's Individual Education Plan (IEP) as medically necessary for the child to obtain a public school education. These services included speech, physical and occupational therapies, nursing services, attendant care (health aid services provided in the classroom), transportation to and from school on days when the child receives an AHCCCS-covered SBC service, and behavioral health services.

Services provided through SBC are specifically intended to allow children to attend school and do not replace medically necessary services provided outside the educational setting. Thus, CRSA's determination of whether services are medically necessary and should be provided to a child shall be made independently of whether that child also is receiving SBC services. If a request is made for services that also are covered under the SBC program for a CRS recipient, the request shall be evaluated on the same basis as any request for a covered service.

50. BUSINESS CONTINUITY AND RECOVERY PLAN

CRSA shall develop a Business Continuity and Recovery Plan to deal with unexpected events that may affect its ability to adequately serve recipients. This plan shall, at a minimum, include planning and training for:

- a. Healthcare facility closure/loss of a major provider;
- b. Electronic/telephonic failure at CRSA or its subcontractor's main place of business;
- c. Complete loss of use of the main site;
- d. Loss of primary computer system/records; and,
- e. How CRSA shall communicate with AHCCCSA in the event of a business disruption.

The Business Continuity and Recovery Plan shall be reviewed annually and updated as needed. All key staff shall be trained and familiar with the Plan. CRSA shall adhere to all elements of the ACOM *Business Continuity and Recovery Plan Policy*.

CRSA shall ensure subcontractors prepare adequate Business Continuity and Recovery Plan and that the subcontractors review their plans annually, updating them as needed. The subcontractor plans shall, at a minimum, address the areas listed above as they apply to the subcontractors.

51. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, CRSA, the subcontractors or providers are required to notify the AHCCCS, Office of Program Integrity immediately of all suspected fraud or abuse. CRSA agrees to promptly (within ten working days of discovery) inform the Office of Program Integrity in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)]. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, CRSA, subcontractors or providers.

As stated in A.R.S. Section 13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material omissions is guilty of a Class 2 felony.

CRSA agrees to permit and cooperate with any onsite review. A review by the AHCCCS Office of Program Integrity may be conducted without notice and for the purpose of ensuring program compliance.

CRSA and the subcontractors shall be in compliance with 42 CFR 438.608. CRSA and the subcontractors must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. The compliance program, which shall both prevent and detect suspected fraud or abuse, must include:

1. The written designation of a compliance officer and a compliance committee that are accountable to CRSA's top management.
2. The Compliance Officer must report directly to management.
3. Effective training and education.
4. Effective lines of communication between the compliance officer and the organization's employees.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Provision for internal monitoring and auditing.
7. Provision for prompt response to problems detected.
8. Written policies, procedure, and standards of conduct that articulate the organization's commitment to and processes for complying with all applicable federal and state standards.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with decision making authority. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.

CRSA and the subcontractors are required to research potential overpayments identified by the AHCCCS, Office of Program Integrity. After conducting a cost benefit analysis to determine if such action is warranted, CRSA should attempt to recover any overpayments identified. The AHCCCS Office of Program Integrity shall be advised of the final disposition of the research and advised of actions, if any, taken by CRSA.

52. TECHNOLOGICAL ADVANCEMENT

CRSA and/or the subcontractors must have a website with links to the following information:

- a. Formulary;
- b. Provider manual;
- c. Policies;
- d. Recipient handbook; and,
- e. Provider listing.

53. BALANCED BUDGET ACT OF 1997 (BBA)

In August 2002, CMS issued final regulations for the implementation of the BBA. AHCCCS continues to review all areas of the regulations to ensure full compliance with the BBA; however, there are some issues that may require further clarification from CMS. Any program changes due to the resolution of the issues will be reflected in amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of the program changes.

54. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives: Reporting of Physician Incentive Plan has been suspended by CMS until further notice. No reporting is required until suspension is lifted.

CRSA or its subcontractors must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479. These regulations prohibit physician incentive plans that directly or indirectly make payments to a doctor or a group as an inducement to limit or refuse medically necessary services to a member. CRSA or its subcontractors are required to disclose all physician incentive agreements to AHCCCSA and to CRS recipients who request them.

CRSA or its subcontractors shall not enter into contractual arrangements that place providers at significant financial risk as defined in CFR 417.479 unless specifically approved in advance by the AHCCCSA, Division of Health Care Management. In order to obtain approval, the following must be submitted to the AHCCCSA, Division of Health Care Management 45 days prior to the implementation of the contract [42 CFR 438.6(g)]:

1. A complete copy of the contract;
2. A plan for the recipient satisfaction survey;
3. Details of the stop-loss protection provided; and,
4. A summary of the compensation arrangement that meets the substantial financial risk definition.

CRSA or its subcontractors shall disclose to AHCCCSA the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCSA or CMS. Please refer to the *Physician Incentive Plan Disclosure by Contractors Policy* for details on providing required disclosures.

CRSA or its subcontractors shall also provide for compliance with physician incentive plan requirements as set forth in 42 CFR 422.208, 422.210 and 438.6(h). These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

Pay for Performance: Any pay for performance that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management, prior to implementation.

55. ADVANCE DIRECTIVES

In accordance with 42 CFR 422.128, CRSA shall maintain policies and procedures addressing advanced directives for adult CRS recipients that specify items a through c below. For the purposes of the advanced directives, an adult CRS recipient is an individual who is eighteen (18) years of age or older.

- a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care, must comply with Federal and State law regarding advance directives for adult members. Requirements include:
 - 1) Maintaining written policies that address the rights of adult CRS recipients to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If an agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.);
 - 2) Provide written information to adult CRS recipients regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)];
 - 3) Documenting in the CRS recipient's medical record whether or not the adult CRS recipient has been provided the information and whether an advance directive has been executed.
 - 4) Not discriminating against a CRS recipient because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
 - 5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by CRS recipients to whom they are assigned to provide services.
- b. CRSA shall ensure providers, which have agreements with the entities described in paragraph a. above, comply with the requirements of subparagraphs a. 2) through 5) above. CRSA shall also encourage health care providers specified in subparagraph a. to provide a copy of the CRS recipient's executed advanced directive, or documentation of refusal, to the acute care PCP for inclusion in the member's medical record.
- c. CRSA shall ensure that adult CRS recipients are provided written information describing the following:
 - 1) A CRS recipient's rights under State law, including a description of the applicable State law;
 - 2) Policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
 - 3) The CRS recipient's right to file complaints directly with AHCCCS; and,
 - 4) Changes to State law as soon as possible, but no later than 90 days after the effective date of the change. [42 CFR 438.6(i)(4)]

56. SURVEY

Unless waived by AHCCCSA, CRSA shall perform its own annual general or focused recipient survey. CRSA shall submit the proposed recipient survey tool, sample and distribution methodology and a timeline to AHCCCSA for review and approval no later than 90 days prior to the intended start of the survey. CRSA shall include questions related to appointment waiting time. AHCCCSA may require inclusion of certain questions. The results and the analysis of the results shall be submitted to the Division of Health Care Management within 45 days of the completion of the survey. CRSA shall ensure that subcontractors utilize recipient survey findings to improve care for Title XIX and Title XXI members. The results of these surveys are public information and must be available to all interested parties upon request.

AHCCCSA may choose to conduct surveys of a representative sample of CRSA's membership and providers. AHCCCSA will consider suggestions from CRSA for questions to be included in each survey. The draft reports from the survey will be shared with CRSA prior to finalization. The results of these surveys will become public information and available to all interested parties upon request. CRSA will be responsible for reimbursing AHCCCSA the cost of the survey.

57. COLLABORATION

CRSA shall collaborate with AHCCCSA in identifying and applying best practices for the community planning process to improve integration of care to enhance the quality of care provided to recipients. During CYE 06, CRSA shall collaborate with AHCCCSA at minimum, but not limited to, in identifying the scope and goals of this collaborative process.

58. PENDING LEGISLATIVE / OTHER ISSUES

The following constitute pending items that may be resolved after the issuance of this contract. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of program changes.

Transportation: AHCCCSA is evaluating its methodology, under capitation, for providing transportation services to its members. Options may include contracting with a centralized transportation broker to provide services to all AHCCCS members.

59. MEDICARE MODERNIZATION ACT (MMA)

The Medicare Modernization Act of 2003 created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. Beginning January 1, 2006, AHCCCS will no longer cover prescription drugs that are covered under Part D for dual eligible members. AHCCCS will not cover prescription drugs for this population whether or not they are enrolled in Medicare Part D. Capitation rates will be adjusted accordingly to account for this change.

Drugs Excluded from Medicare Part D: AHCCCS will continue to cover those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, contractor formularies and prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plans formulary are not considered excluded drugs and will not be covered by AHCCCS.

As the Medicare Modernization Act is fully implemented, there may be required changes to business practices of AHCCCS and contractors or the contract. AHCCCS will identify potential impacts and work with contractors to implement necessary program changes.

[END OF SECTION D]

SECTION E: CONTRACT CLAUSES

1. APPLICABLE LAW

Arizona Law - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

2. AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this contract based on those changes.

3. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract, including all attachments and executed amendments and modifications; AHCCCS policies and procedures.

4. CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State.

5. SEVERABILITY

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

6. RELATIONSHIP OF PARTIES

The Contractor of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

7. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any right nor delegate any duty under this contract without prior written approval of the Contracting Officer, who will not unreasonably withhold such approval.

8. GENERAL INDEMNIFICATION

The Contractor shall defend, indemnify and hold harmless the State from any claim, demand, suit, liability, judgment and expense (including attorney's fees and other costs of litigation) arising out of or relating to injury, disease, or death of persons or damage to or loss of property resulting from or in connection with the negligent performance of this contract by the Contractor, its agents, employees, and subcontractors or anyone for whom the Contractor may be responsible. The obligations, indemnities and liabilities assumed by the Contractor under this paragraph shall not extend to any liability caused by the negligence of the State or its employees. The Contractor's liability shall not be limited by any provisions or limits of insurance set forth in this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph. The Administration shall bear no liability for subcontracts that a Contractor executes with other parties for the provision of administrative or management services medical services or covered health care services, or for any other purposes.

9. INDEMNIFICATION – PATENT AND COPYRIGHT

The Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits. [42CFR 438.6(f)(1), 42 CFR 438.100(d)]

11. ADVERTISING AND PROMOTION OF CONTRACT

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

12. PROPERTY OF THE STATE

Except as provided in this paragraph, any materials, including reports, computer programs and other deliverables, created under this contract are the sole property of AHCCCSA. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of AHCCCSA.

If the Contractor believes that any reports, computer programs, or other deliverables created under this contract and submitted to AHCCCSA contains trade secrets or other proprietary data, the Contractor shall include with the submission a statement that explains and supports the Contractor's claim that the submission contains such information. The Contractor also shall stamp as confidential or otherwise specifically identify in the submission all trade secrets and other proprietary data that the Contractor believes should remain confidential. AHCCCSA shall review the statement and information and shall determine whether the information is a trade secret or other proprietary data that shall remain confidential. If AHCCCSA determines that the information is not a trade secret or other proprietary data that shall remain confidential, AHCCCSA will inform the Contractor in writing of such determination. AHCCCSA will not voluntarily disclose any information deemed confidential except as required by law. Before any such disclosures of confidential information are made, AHCCCSA will notify the Contractor in writing.

13. THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

14. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or continue performing this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

15. TERMINATION FOR CONFLICT OF INTEREST

AHCCCSA may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCSA is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

16. GRATUITIES

AHCCCSA may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract,

including the making of any determination or decision about contract performance. AHCCCSA, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

17. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b)]. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCSA may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

18. TERMINATION FOR CONVENIENCE

AHCCCSA reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, return receipt requested, to the Contractor of the termination at least 90 days before the effective date of the termination. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCSA. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

19. RESERVED

20. TERMINATION - AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

21. RIGHT OF OFFSET

AHCCCSA shall be entitled to offset against any amounts due the Contractor any expenses or costs incurred by AHCCCSA concerning the Contractor's non-conforming performance or failure to perform the contract.

22. NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCSA under this contract are not exclusive.

23. NON-DISCRIMINATION

The Contractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Contractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability.

24. EFFECTIVE DATE

The effective date of this contract shall be the date referenced on page 1 of this contract.

25. INSURANCE

A certificate of insurance naming the State of Arizona and AHCCCSA as the "additional insured" must be submitted to AHCCCSA within 10 days of notification of contract award and prior to commencement of any services under this contract. This insurance shall be provided by carriers rated as "A+" or higher by the A.M. Best Rating Service. The following types and levels of insurance coverage are required for this contract:

- a. Commercial General Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others as a result of accidents on the premises of or as the result of operations of the Contractor.
- b. Commercial Automobile Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others resulting from accidents caused by vehicles operated by the Contractor.
- c. Workers Compensation: Provides coverage to employees of the Contractor for injuries sustained in the course of their employment. Coverage must meet the obligations imposed by Federal and State statutes and must also include Employer's Liability minimum coverage of \$100,000. Evidence of qualified self-insured status will also be considered.
- d. Professional Liability (if applicable): Provides coverage for alleged professional misconduct or lack of ordinary skills in the performance of a professional act of service.

The above coverages may be evidenced by either one of the following:

- a. The State of Arizona Certificate of Insurance: This is a form with the special conditions required by the contract already pre-printed on the form. The Contractor's agent or broker must fill in the pertinent policy information and ensure the required special conditions are included in the Contractor's policy.
- b. The Accord form: This standard insurance industry certificate of insurance does not contain the pre-printed special conditions required by this contract. These conditions must be entered on the certificate by the agent or broker and read as follows:

The State of Arizona and Arizona Health Care Cost Containment System are hereby added as additional insured. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies, boards, departments or commissions shall be in excess

of that provided by the insured Contractor. No policy shall expire, be canceled or materially changed without 30 days written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company.

26. DISPUTES

The exclusive manner for the Contractor to assert any claim, grievance, dispute or demand against AHCCCS shall be in accordance with Title 9 A.A.C. Chapter 34, Article 4. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

27. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

28. INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCSA, and any approved subcontracts are hereby incorporated by reference into the contract.

29. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

30. CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within thirty (30) days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 15, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted sixty (60) days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment.

31. TYPE OF CONTRACT

Firm fixed-price.

32. AMERICANS WITH DISABILITIES ACT

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting AHCCCS Administration.

33. WARRANTY OF SERVICES

The Contractor warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

34. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

35. CONFLICT OF INTEREST

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or the Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

36. DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall not, without prior written approval from AHCCCSA, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCSA personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCSA.

37. COOPERATION WITH OTHER CONTRACTORS

AHCCCSA may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCSA employees or designated agents, and carefully fit its own work to such other contractors' work. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCSA employees.

38. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCSA upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCSA.

39. OWNERSHIP OF INFORMATION AND DATA

Any data or information system, including all software, documentation and manuals, developed by the Contractor pursuant to this contract, shall be deemed to be owned by AHCCCSA. The Federal government reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal government purposes, such data or information system, software, documentation and manuals. Proprietary software which is provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership or licensing provisions of this section.

Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall be deemed to be owned by AHCCCSA. The ownership provision is in consideration of the Contractor's use of public funds in collecting or preparing such data, information and reports. These items shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCSA. Subject to applicable state and Federal laws and regulations, AHCCCSA shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information. At the termination of the contract, the Contractor shall make available all such data to AHCCCSA within 30 days following termination of the contract or such longer period as approved by AHCCCSA, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCSA and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74 and 45 CFR Parts 6 and 8.

40. AHCCCSA RIGHT TO OPERATE CONTRACTOR

If, in the judgment of AHCCCSA, the Contractor's performance is in material breach of the contract or the Contractor is insolvent, AHCCCSA may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other contractors.

If AHCCCSA undertakes direct operation of the Contractor, AHCCCSA, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the Contract Performance failure to the satisfaction of AHCCCSA. AHCCCSA shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party.

All reasonable expenses of AHCCCSA related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any

office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

41. AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable AHCCCS Rule R9-22-519, -520 and -521 and AHCCCS policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCSA staff and allow them reasonable access to the Contractor's staff, subcontractors, recipients, and records. [42 CFR 438.6(g)]

At any time during the term of this contract, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCSA and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts. [42 CFR 438.242(b)(3)]

AHCCCSA, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

42. LOBBYING

No funds paid to the Contractor by AHCCCSA, or interest earned thereon, shall be used for the purpose of influencing an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan or cooperative agreement. The Contractor shall disclose if any funds other than those paid to the Contractor by AHCCCSA have been used or will be used to influence the persons and entities indicated above and will assist AHCCCSA in making such disclosures to CMS.

43. CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

44. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial data must be submitted concurrent with the data. Data certification must be submitted concurrently with the certified data. Certification may be provided by the Contractor Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO. [42 CFR 438.604, 606]

45. OFF SHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive

data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or “overhead” services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. Due to security and identity protection concerns, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers.

46. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the contractor.

47. TERM OF CONTRACT AND OPTION TO REVIEW

The initial term of this contract shall be for one (1) year, with annual options to extend. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment. [42 CFR 438.610(c)(3)] When AHCCCS issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted sixty (60) days from the date of mailing by AHCCCS, even if the extension has not been signed by ADHS, unless within that time ADHS notifies AHCCCS in writing that it refuses to sign the extension. Any disagreement between the parties regarding the extension of the contract or the terms of its renewal will be considered a dispute within the meaning of Section E, Paragraph 26, Disputes, and administered accordingly.

[END OF SECTION E]

ATTACHMENT A: MINIMUM CRSA SUBCONTRACT PROVISIONS

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Contractor under this subcontract may be assigned without the prior approval of the Children's Rehabilitative Services Administration (CRSA). No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from CRSA. (AAC R2-7-305)

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCSA and/or CRSA may undertake or award other contracts for additional or related work to the work performed by the contractor and the contractor shall fully cooperate with such other contractors, subcontractors or state employees. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee. (AAC R2-7-308)

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING

By signing this contract, the Contractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation therefrom. If the Contractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCSA simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Contractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCSA requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements. (CLIA of 1988; 42 CFR 493, Subpart A)

6. COMPLIANCE WITH AHCCCSA RULES RELATING TO AUDIT AND INSPECTION

The Contractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. If the Contractor is an inpatient facility,

the Contractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCSA. [ARS 41-2548; 45 CFR 74.48 (d)]

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Contractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract. [Requirement for FFP, 42 CFR 434.70, 42 CFR 438.6(1)]

8. CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903, 41-1959 and 46-135, AHCCCS Rules and Health Insurance Portability and Accountability Act (Public Law 107-191, 110 Statutes 1936).

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this contract and the CRSA Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S. § Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules.

11. ENCOUNTER DATA REQUIREMENT

If the Contractor does not bill CRSA (e.g., Contractor is capitated), the Contractor shall submit encounter data to CRSA in a form acceptable to AHCCCSA.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCSA, CRSA or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract. [ARS 36-2903. C., (8.); ARS 36-2903.02; AAC 9-22-522]

13. FRAUD AND ABUSE

If the Contractor discovers, or is made aware, that an incident of potential fraud or abuse has occurred, the Contractor shall report the incident to the CRSA as well as to AHCCCSA, Office of Program Integrity. All incidents of potential fraud should be reported to AHCCCSA, Office of the Director, Office of Program Integrity. (ARS 36-2918.01; AAC R9-22-511)

14. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and CRSA for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

15. INSURANCE

[This provision applies only if the Contractor provides services directly to AHCCCS members]

The Contractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet AHCCCS requirements. The Contractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Contractor, shall not limit the responsibility of Contractor to indemnify, keep and save harmless and defend the State and AHCCCSA, CRSA, their agents, officers and employees as provided herein. Furthermore, the Contractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCSA shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74)

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state laws and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services. [AAC R9-22-702, R9-22-201(J), 42 CFR 438.106]

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Contractor shall be registered with AHCCCSA and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

18. NON-DISCRIMINATION REQUIREMENTS

The Contractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Contractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order # 99-4 & AAC R9-22-513)

19. PRIOR AUTHORIZATION AND UTILIZATION REVIEW

The Contractor and CRSA shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies. (AAC R9-22-522)

20. RECORDS RETENTION

The Contractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCSA and working papers used in the preparation of reports to AHCCCSA. The Contractor shall comply with all specifications for record keeping established by AHCCCSA. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records

shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCSA.

The Contractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCSA, State or Federal government.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCSA, shall be retained by the Contractor for a period of five years after the date of final disposition or resolution thereof. (45 CFR 74.53; ARS 41-2548)

21. SEVERABILITY

If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

22. SUBJECTION OF CONTRACT

The terms of this contract shall be subject to the applicable material terms and conditions of the contract existing between CRSA and AHCCCSA for the provision of covered services.

23. TERMINATION OF CONTRACT

CRSA may, by written notice to the Contractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Contractor, or any agent or representative of the Contractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Contractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, CRSA shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Contractor in providing any such gratuities to any such officer or employee. (AAC R2-5-501; ARS 41-2616 C.; 42 CFR 434.6, a. (6))

24. VOIDABILITY OF CONTRACT

This subcontract is voidable and subject to immediate termination by CRSA upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without CRSA's prior written approval.

25. WARRANTY OF SERVICES

The Contractor, by execution of this contract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

26. FEDERAL IMMIGRATION AND NATIONALITY ACT

All subcontracts must contain the following provision by October 1, 2006

The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the contractor.

[END OF ATTACHMENT]

ATTACHMENT B: PERIODIC REPORT REQUIREMENTS

The following table is a summary of the reporting requirements for CRSA and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit CRSA's responsibilities in any manner.

Annual Reports

Report	Reporting Period	Due Date	AHCCCS Contact
<i>Written Description of Covered Services</i> (Sec. D., ¶3, Coordination of Care)	Annual	July 1	DHCM, BH/CRS Operations
<i>Medical Eligibility Criteria Policy</i> (Sec. D., ¶6, Eligibility for Services)	Annual	July 1	DHCM, BH/CRS Operations
<i>Clinic Contact List</i> (Sec. D., ¶3, Coordination of Care)	Annual	July 1	DHCM, BH/CRS Operations
<i>Business Continuity and Recovery Plan Summary</i> (Business Continuity and Recovery Plan Policy)	Annual	July 15	DHCM, BH/CRS Operations
<i>Cultural Competency Plan and Assessment of Effectiveness</i> (Sec. D., ¶48, Cultural Competency)	Annual	August 14	DHCM, BH/CRS Operations
<i>Provider Network Development and Management Plan</i> (Sec. D., ¶18, Network Management)	Annual	August 14	DHCM, BH/CRS Operations
<i>CRSA's Organizational chart and related documents</i> (Sec. D., ¶11, Staff Requirements and Support Services)	Annual	August 31	DHCM, BH/CRS Operations
<i>Recipient Handbook</i> (Sec. D., ¶9, Recipient Information)	NA	September 1	DHCM, BH/CRS Operations
<i>Recipient Survey Tool, Sample, Distribution Methodology and Timeline</i> (Sec. D., ¶56, Survey)	Annual	90 days prior to the intended start	DHCM, BH/CRS Operations
<i>Recipient Survey Results and Analysis</i> (Sec. D., ¶56, Survey)	Annual	Within 45 days of the completion	DHCM, BH/CRS Operations

Report	Reporting Period	Due Date	AHCCCS Contact
<i>Analysis of Encounter Data, Detailed by Member, for all Services Received by CRS Recipients</i> (Sec. D., ¶35, Data Exchange Requirements)	Annual	Within 6 months of receipt from AHCCCS	DHCM, BH/CRS Operations
<i>Performance Review and the Corrective Action Plan of CRSA Subcontractors</i> (Sec. D., ¶39, CRSA Subcontracts)	Annual	Upon completion	DHCM, BH/CRS Operations
<i>Draft Annual Audit Report</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	September 30	DHCM, Financial Manager
<i>Draft Management Letter</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	September 30	DHCM, Financial Manager
<i>Final Annual Audit Report</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	October 31	DHCM, Financial Manager
<i>Final Management Letter</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	October 31	DHCM, Financial Manager
<i>Accountant's Report on Compliance</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	October 31	DHCM, Financial Manager
<i>Reconciliation – Annual Audit and Plan Year-to-Date Financial Report Information</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	October 31	DHCM, Financial Manager
<i>Financial Disclosure Report</i> (Sec. D., ¶21, Financial Operations)	Prior contract year	October 31	DHCM, Financial Manager
<i>Performance Improvement Project Proposal (Initial/baseline year of the project)</i> (Sec. D., ¶13, QM/UM)	Annual	October 1	DHCM, CQM
<i>Performance Improvement Project Re-measurement Report</i> (Sec. D., ¶13, QM/UM)	Annual	October 1	DHCM, CQM
<i>Performance Improvement Project Final Report</i> (Sec. D., ¶13, QM/UM)	Annual	October 1	DHCM, CQM

<i>Quality Management/Utilization Management Plan and Evaluation</i> (Sec. D., ¶13, QM/UM)	Annual	October 1	DHCM, CQM
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Quarterly Reports

Report	Reporting Period	Due Date	AHCCCS Contact
<i>AHCCCS Quarterly Appeal and Claims Dispute Report</i> (Sec. D ¶47, AHCCCS Quarterly Appeal and Claim Dispute Report)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, BH/CRS Operations
<i>Clinic Contact List</i> (Sec. D ¶3, Coordination of Care)	NA	July 1 October 1 January 1 April 1	DHCM, BH/CRS Operations
<i>Quarterly QM Report</i>	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, CQM
<i>Quarterly UM Report</i>	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, Medical Management
<i>Quarterly Inpatient Hospital Showing</i>	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, Medical Management
<i>Quarterly Financial Report</i> (Sec. D., ¶21, Financial Operations)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 30 February 28 May 31 August 31	DHCM, Financial Manager
<i>Certification Statement</i> (Sec. D., ¶21, Financial Operations)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 30 February 28 May 31 August 31	DHCM, Financial Manager

Monthly Reports

Report	Due Date	AHCCCS Contact
<i>Corrected Pended Encounter Data</i> (Attachment E, Encounter Submission Requirements)	Monthly according to established schedule	DHCM, Encounter Administrator
<i>New Day Encounter</i> (Attachment E, Encounter Submission Requirements)	Monthly according to established schedule	DHCM, Encounter Administrator

Ad Hoc Reports

Report	Due Date	AHCCCS Contact
<i>Changes in CRSA Key Staff</i> (Sec. D., ¶11, Staff Requirements and Support Services)	Within 7 days of change	DHCM, BH/CRS Operations
<i>Medical Eligibility Criteria Policy</i> (Sec. D., ¶6, Eligibility for Services)	Upon revision	DHCM, BH/CRS Operations
<i>CRSA Subcontracts</i> (Sec. D., ¶39, CRSA Subcontracts)	At least 30 days prior to the beginning date of the contract	DHCM, BH/CRS Operations

Report	Due Date	AHCCCS Contact
<i>Written Description of Covered Services</i> (Sec. D., ¶3, Coordination of Care)	Upon revision	DHCM, BH/CRS Operations
<i>Network Impairment Notice</i> (Sec. D., ¶18, Network Management)	Within 1 day of awareness	DHCM, BH/CRS Operations
<i>Subcontractor Non-Compliance and the Corrective Measures Taken</i> (Sec. D. ¶40, Subcontractor Compliance with Contract Requirements)	Within 5 working days of any action taken	DHCM, BH/CRS Operations
<i>Eligible Person Fraud/Abuse Report</i> (Sec. D., ¶51, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
<i>Provider Fraud/Abuse Report</i> (Sec. D., ¶51, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
<i>Medical Records for Data Validation</i> (Attachment E, Encounter Submission Requirements)	90 days after the request received from AHCCCSA	DHCM, Encounter Administrator
<i>Third Party Change Form</i> (Sec. D., ¶30, Coordination of Benefits and Third Party Liability)	Within 10 days of discovery	Division of Member Services

[END OF ATTACHMENT]

ATTACHMENT C(1): ENROLLEE GRIEVANCE SYSTEM

CRSA or its subcontractors shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. CRSA or its subcontractors shall provide the ACOM *Enrollee Grievance Policy* to all providers and subcontractors at the time of contract. CRSA or its subcontractors shall also furnish this information to CRS recipients within a reasonable time after CRSA or its subcontractors receive notice of the CRS recipient's enrollment. Additionally, CRSA or its subcontractors shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to CRS recipients describing the Grievance System including the grievance process, the appeals process, CRS recipient rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the subcontractor's service area and in an easily understood language and format. CRSA or its subcontractors shall inform CRS recipients that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how CRS recipients may obtain this information.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be translated into the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the CRS recipient that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how CRS recipients may obtain this information. This information must be in large, bold print appearing in a prominent location on the first page of the document.

If a request is received by CRSA or its subcontractors from a CRS recipient with limited English proficiency, these documents shall be translated either orally or in writing, into the CRS recipient's language.

At a minimum, CRSA of its subcontractors' Grievance System Standards and Policy shall specify:

1. That CRSA or its subcontractors shall maintain records of all grievances and appeals.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes describing the right to hearing, the method for obtaining a hearing, the rules which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal.
3. The availability of assistance in the filing process and CRSA or its subcontractors' toll-free numbers that a CRS recipient can use to file a grievance or appeal by phone if requested by the CRS recipient.
4. That CRSA or its subcontractors shall acknowledge receipt of each grievance and appeal. For Appeals, CRSA or its subcontractors shall acknowledge receipt of standard appeals in writing within five working days of receipt and within one working day of receipt of expedited appeals.
5. That CRSA or its subcontractors shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as.
6. That CRSA or its subcontractors shall ensure that individuals who make decisions regarding grievances

and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the CRS recipient's condition or disease.

7. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 calendar days if the CRS recipient requests the extension or if CRSA or its subcontractors establishes a need for additional information and that the delay is in the CRS recipient's interest.
8. That if CRSA or its subcontractors extends the timeframe for resolution of an appeal when not requested by the CRS recipient, CRSA or its subcontractors shall provide the CRS recipient with written notice of the reason for the delay.
9. The definition of grievance as a CRS recipient's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.
10. That a CRS recipient must file a grievance with CRSA or its subcontractors and that the CRS recipient is not permitted to file a grievance directly with the State.
11. That CRSA or its subcontractors must dispose of each grievance in accordance with the Division of Health Care Management ACOM *Enrollee Grievance Policy*, but in no case shall the timeframe exceed 90 days.
12. The definition of action as the [42 CFR 438.400(b)]:
 - a. Denial or limited authorization of a requested service, including the type or level of service;
 - b. Reduction, suspension, or termination of a previously authorized service;
 - c. Denial, in whole or in part, of payment for a service;
 - d. Failure to provide services in a timely manner;
 - e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
 - f. Denial of a rural CRS recipient's request to obtain services outside CRSA or its subcontractors' network under 42 CFR 438.52(b)(2)(ii), when CRSA or its subcontractors is the only Contractor in the rural area.
13. The definition of a service authorization request as a CRS recipient's request for the provision of a service [42 CFR 431.201].
14. The definition of appeal as the request for review of an action, as defined above.
15. Information explaining that a provider acting on behalf of a CRS recipient and with the CRS recipient's written consent, may file an appeal.
16. That a CRS recipient may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of CRSA or its subcontractors to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural CRS recipient's request to obtain services outside the CRS network under 42 CFR 438.52(b)(2)(ii) when CRS is the only contractor in the rural area.

17. The definition of a standard authorization request and that for standard authorization decisions, CRSA or its subcontractors must provide a Notice of Action to the CRS recipient as expeditiously as the CRS recipient's health condition requires, but not later than 14 calendar days following the receipt of the authorization with a possible extension of up to 14 calendar days if the CRS recipient or provider requests an extension or if CRSA or its subcontractors establishes a need for additional information and delay is in the CRS recipient's best interest. [42 CFR 438.210(d)(1)]
18. The definition of an expedited authorization request and that for expedited authorization decisions, CRSA or its subcontractors must provide a Notice of Action to the CRS recipient as expeditiously as the CRS recipient's health condition requires, but not later than 3 working days following the receipt of the authorization with a possible extension of up to 14 calendar days if the CRS recipient or provider requests an extension or if CRSA or its subcontractors establishes a need for additional information and delay is in the CRS recipient's interest. [42 CFR 438.210(d)(2)]
19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If CRSA or its subcontractors extends the timeframe to make a standard or expedited authorization decision, CRSA or its subcontractors must give the CRS recipient written notice of the reason to extend the timeframe and inform the CRS recipient of the right to file a grievance if the CRS recipient disagrees with the decision. CRSA or its subcontractors must issue and carry out its decision as expeditiously as the CRS recipient's health condition requires and no later than the date the extension expires.
20. That CRSA or its subcontractors shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.
21. The definition of a standard appeal and that CRSA or its subcontractors shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect.
22. The definition of an expedited appeal and that CRSA or its subcontractors shall resolve all expedited appeals not later than three working days from the date CRSA or its subcontractors receives the appeal (unless an extension is in effect) where CRSA or its subcontractors determines (for a request from the CRS recipient), or the provider (in making the request on the CRS recipient's behalf indicates) that the standard resolution timeframe could seriously jeopardize the CRS recipient's life or health or ability to attain, maintain or regain maximum function. CRSA or its subcontractors shall make reasonable efforts to provide oral notice to a CRS recipient regarding an expedited resolution appeal.
23. That if CRSA or its subcontractors denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. CRSA or its subcontractors must make reasonable efforts to give the CRS recipient prompt oral notice and follow-up within two calendar days with a written notice of the denial of expedited resolution.
24. That a CRS recipient shall be given 60 days from the date of CRSA or its subcontractors' Notice of Action to file an appeal.
25. That CRSA or its subcontractors shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(f) below; 2) at least 5 days before the date of action in the case of suspected fraud; 3) at the

time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a request for a standard service authorization which has been denied or reduced unless an extension is in effect; 5) within three business days from receipt of an expedited service authorization request unless an extension is in effect. As described below, CRSA or its subcontractors may elect to mail the Notice of Action no later than the date of action when:

- a. CRSA or its subcontractors receives notification of the death of a CRS recipient;
 - b. The CRS recipient signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
 - c. The CRS recipient is admitted to an institution where he is ineligible for further services;
 - d. The CRS recipient's address is unknown and mail directed to the CRS recipient has no forwarding address;
 - e. The CRS recipient has been accepted for Medicaid in another local jurisdiction.
26. That CRSA or its subcontractors include, as parties to the appeal, the CRS recipient, the CRS recipient's legal representative, or the legal representative of a deceased CRS recipient's estate.
 27. That the Notice of Action must explain: 1) the action CRSA or its subcontractors has taken or intends to take, 2) the reasons for the action, 3) the CRS recipient's right to file an appeal with CRSA or its subcontractors, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the CRS recipient's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the CRS recipient may be required to pay for the cost of these services.
 28. That benefits shall continue only if: 1) the CRS recipient files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the CRSA or its subcontractors' action, 2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, 3) the services were ordered by an authorized provider, 4) the original period covered by the original authorization has not expired, and 5) the CRS recipient requests a continuation of benefits.
 29. That for appeals, CRSA or its subcontractors provides the CRS recipient a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that CRSA or its subcontractors informs the CRS recipient of the limited time available in cases involving expedited resolution.
 30. That for appeals, CRSA or its subcontractors provides the CRS recipient and his representative the opportunity before and during the appeals process to examine the CRS recipient's case file including medical records and other documents considered during the appeals process.
 31. That CRSA or its subcontractors must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a CRS recipient's appeal.
 32. That CRSA or its subcontractors shall provide written Notice of Appeal Resolution to the CRS recipient and the CRS recipient's representative or the representative of the deceased CRS recipient's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of CRS recipients: a) the CRS recipient's right to request a State fair

hearing (including the requirement that the recipient must file the request for a hearing in writing) no later than 30 days after the date the recipient receives CRSA or its subcontractors' notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the CRS recipient may be held liable for the cost of benefits if the hearing decision upholds CRSA or its subcontractors.

33. That CRSA or its subcontractors continues extended benefits originally provided to the CRS recipient until any of the following occurs: 1) the CRS recipient withdraws appeal, 2) the CRS recipient has not specifically requested continued benefits pending a hearing decision within 10 days of CRSA or its subcontractors mailing of the appeal resolution notice, 3) the AHCCCS Administration issues a state fair hearing decision adverse to the CRS recipient or 4) time period or service limits of a previously authorized service has been met.
34. That if the CRS recipient files a request for hearing CRSA or its subcontractors must ensure that the case file and all supporting documentation is received by the AHCCCSA, Office of Legal Assistance (OLA) as specified in the OLA request. The file provided by CRSA or its subcontractors must contain a cover letter that includes:
 - a. CRS recipient's name;
 - b. CRS recipient's AHCCCS I.D. number;
 - c. CRS recipient's address;
 - d. CRS recipient's phone number (if applicable);
 - e. Date of receipt of the appeal; and,
 - f. Summary of CRSA or its subcontractors' actions undertaken to resolve the appeal and summary of the appeal resolution.
35. The following material shall be included in the file sent by CRSA or its subcontractors:
 - a. The CRS recipient's written request for hearing;
 - b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
 - c. CRSA or its subcontractors' resolution notice; and,
 - d. Other information relevant to the resolution of the appeal.
36. That if CRSA or its subcontractors or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished while the appeal was pending, CRSA or its subcontractors shall authorize or provide the services promptly and as expeditiously as the CRS recipient's health condition requires.
37. That if CRSA or its subcontractors or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, CRSA or its subcontractors shall pay for those services, as specified in policy and/or regulation.
38. That if CRSA or its subcontractors or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, CRSA or its subcontractors may recover the cost of those services from the CRS recipient.

[END OF ATTACHMENT]

ATTACHMENT C(2): PROVIDER CLAIM DISPUTE SYSTEM STANDARDS AND POLICY

CRSA or its subcontractors shall have in place a written grievance system policy for providers regarding adverse actions taken by CRSA or its subcontractors. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claim dispute policy shall include the following provisions:

1. The Provider Claim Dispute policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
2. The Provider Claim Dispute policy must specify that all claim disputes challenging claim denials or recoupments, must be filed with CRSA or its subcontractors no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.
3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.
4. A log is maintained for all claim disputes containing sufficient information to identify the Provider, date of receipt, nature of the claim dispute and the date the claim dispute is resolved. Separate logs must be maintained for provider and CRS recipient claim dispute.
5. Within five working days of receipt, the Provider is informed by letter that the claim dispute has been received.
6. Each claim dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.
7. All documentation received by CRSA or its subcontractors during the claim dispute process is dated upon receipt.
8. All claim disputes are filed in a secure designated area and are retained for five years following CRSA or its subcontractors' decision, the Administration's decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.
9. A copy of CRSA or its subcontractors' Notice of Decision(hereafter referred to as Decision) will be communicated in writing to all parties. The Decision must include and describe in detail, the following:
 - a. the nature of the claim dispute
 - b. the issues involved
 - c. the reasons supporting CRSA or its subcontractors' Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
 - d. the Provider's right to request a hearing by filing a written request for hearing to CRSA or its subcontractors no later than 30 days after the date the Provider receives CRSA or its subcontractors' decision.

- e. If the claim dispute is overturned, the requirement that CRSA or its subcontractors shall reprocess and pay the claim(s) in a manner consistent with the Decision within ten business days of the date of the Decision.
10. If the Provider files a written request for hearing, CRSA or its subcontractors must ensure that all supporting documentation is received by the AHCCCSA, Office of Legal Assistance, no later than five working days from the date CRSA or its subcontractors receives the provider's written hearing request from AHCCCSA, Office of Legal Assistance. The file sent by CRSA or its subcontractors must contain a cover letter that includes:
- a. Provider's name
 - b. Provider's AHCCCS ID number
 - c. Provider's address
 - d. Provider's phone number (if applicable)
 - e. the date of receipt of claim dispute
 - f. a summary of CRSA or its subcontractors' actions undertaken to resolve the claim dispute and basis of the determination
11. The following material shall be included in the file sent by CRSA or its subcontractors:
- a. written request for hearing filed by the Provider
 - b. copies of the entire file which includes pertinent records; and CRSA or its subcontractors' Decision
 - c. other information relevant to the Notice of Decision of the claim dispute
12. If CRSA or its subcontractors' Decision regarding a claim dispute is reversed through the appeal process, CRSA or its subcontractors shall reprocess and pay the claim(s) in a manner consistent with the Decision within ten business days of the date of the Decision.

[END OF ATTACHMENT]

ATTACHMENT D: COST SHARING COPAYMENTS

I. EXEMPT POPULATIONS (REGARDLESS OF RATE CODE)

The following populations are **exempt from copayments for ALL services (\$0 copay)**:

- All recipients under the age of 19, including all KidsCare members
- All Pregnant Women
- All ALTCS enrolled members
- All persons with Serious Mental Illness receiving RBHA services
- All recipients who are receiving CRS services
- SOBRA Family Planning Services Only members

Additionally, **no recipient** may be asked to make a copayment for family planning services or supplies.

II. STANDARD COPAYMENTS APPLY TO THE TITLE XIX WAIVER GROUP

*Services to this population may **not** be denied for failure to pay copayment.*

- Effective May 1, 2004, the standard copayments apply to the Title XIX Waiver Group, including RBHA General Mental Health and Substance Abuse service recipients. The standard copayments are as follows:

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	\$ 0 per Rx
Brand Name Prescriptions when generic is available	\$ 0
NON EMERGENCY USE OF ER	\$ 5
Physician Office Visits	\$ 1

III. STANDARD COPAYMENTS APPLY TO THE FOLLOWING POPULATIONS

*Services to this population may **not** be denied for failure to pay copayment.*

- AHCCCS for Families with Children
- Supplemental Security Income with and without Medicare

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	\$ 0
Brand Name Prescriptions when generic is available	\$ 0
Non Emergency Use of ER	\$ 5
Physician Office Visits	\$ 1

IV. OTHER CO-PAYS

HIFA Parents (Parents of KidsCare and SOBRA Children)

- Copayment is not mandatory
- **EXCEPTION: Native American Health Plan Enrolled Parents are exempt from any**

copayment

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	\$ 0
Brand Name Prescriptions when generic is available	\$ 0
Non Emergency Use of ER	\$ 5
Physician Office Visits	\$ 0

[END OF ATTACHMENT]

ATTACHMENT E: ENCOUNTER SUBMISSION REQUIREMENTS

CRSA will be assessed sanctions for noncompliance with encounter submission requirements. AHCCCSA may also perform special reviews of encounter data, such as comparing encounter reports to CRSA' claims files. Any findings of incomplete or inaccurate encounter data may result in the imposition of sanctions and/or requirement of a corrective action plan.

Pended Encounter Corrections

CRSA must resolve all pended encounters within 120 days of the original processing data. Sanctions will be imposed according to the following schedule for each encounter pended for more than 120 days unless the pend is due to AHCCCSA error:

0 – 120 days	121 – 180 days	181 – 240 days	241 – 360 days	361 + days
No sanction	\$ 5 per month	\$ 10 per month	\$ 15 per month	\$ 20 per month

“AHCCCSA error” is defined as a pended encounter which (1) AHCCCSA acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to the database reference table, or further research by AHCCCSA. AHCCCSA reserves the right to adjust the sanction amount if circumstances warrant.

Written preliminary results of all pended encounters will be sent to CRSA for review and comment. CRSA will have 45 days to review results and provide AHCCCSA with additional documentation that would affect the final calculation of sanctions.

When CRSA notifies AHCCCSA in writing that the resolution of a pended encounter depends on AHCCCSA rather than CRSA, AHCCCSA will respond in writing within 30 days of receipt of such notification. The AHCCCSA response will report the status of each pending encounter problem or issue in question.

Pended encounters will not qualify as AHCCCSA errors if AHCCCSA reviews CRSA' notification and asks CRSA to research the issue and provide additional substantiating documentation, or if AHCCCSA disagrees with CRSA' claim of AHCCCSA error. If a pended encounter being researched by AHCCCSA is later determined not to be caused by AHCCCSA error, CRSA may be sanctioned retroactively.

Before imposing sanctions, AHCCCSA will notify CRSA in writing of the total number of sanctionable encounters pended more than 120 days.

Pended encounters shall not be deleted by CRSA or the subcontractors as a means of avoiding sanctions for failure to correct encounters within 120 days. CRSA and the subcontractors shall document deleted encounters and shall maintain a record of the deleted CRNs with appropriate reasons indicated. CRSA and the subcontractors shall, upon request, make this documentation available to AHCCCSA for review.

Encounter Validation Studies

Per CMS requirement, AHCCCSA will conduct encounter validation studies of CRSA' encounter submissions, and sanction CRSA for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical

record or other source with CRSA' submitted encounter data. Any and all covered services may be validated as part of these studies. Encounter validation studies will be conducted at least yearly.

The following reflects AHCCCSA's encounter validation study process and sanction policy. AHCCCSA may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with CMS. CRSA will be notified in writing of any significant change in study methodology.

AHCCCSA will conduct two encounter validation studies. Study "A" examines non-institutional services (form HCFA 1500/837P encounters), and Study "B" examines institutional services (form UB-92/837I encounters).

AHCCCSA will notify CRSA in writing of the sanction amounts and of the selected data needed for encounter validation studies. CRSA will have 90 days to submit the requested data to AHCCCSA. In the case of medical records requests, CRSA' failure to provide AHCCCSA with the records requested within 90 days may result in a sanction of \$1,000 per missing medical record. If AHCCCSA does not receive a sufficient number of medical records from CRSA to select a statistically valid sample for a study, CRSA may be sanctioned up to five percent (5%) of its annual capitation payment.

The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. These criteria are defined as follows:

Timeliness: The time elapsed between the date of service and the date that the encounter is received at AHCCCS. Ninety-five percent of encounters must be received by AHCCCSA no later than 240 days after the end of the month in which the service was rendered, or the effective date of identification as a behavioral health recipient, whichever is later. For all encounters for which timeliness is evaluated, a sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter record is received by AHCCCSA more than 240 days after the date determined above. It is anticipated that the sanction amount will be \$1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. CRSA will be notified of the sanction amount in effect for the studies at the time the studies begin.

Correctness: A correct encounter contains a complete and accurate description of AHCCCS covered services provided to a member. A sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter is incomplete or incorrectly coded. It is anticipated that the sanction amount will be \$1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. CRSA will be notified of the sanction amount in effect for the studies at the time the studies begin.

Omission of data: An encounter not submitted to AHCCCSA or an encounter inappropriately deleted from AHCCCSA's pending encounter file or historical files in lieu of correction of such record. For Study "A" and for Study "B", a sanction per encounter error extrapolated to the population of encounters may be assessed for an omission. It is anticipated that the sanction amount will be \$5.00 per error extrapolated to the population of encounters for Study "A" and \$10.00 per error extrapolated to the population of encounters for Study "B"; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. CRSA will be notified of the sanction amount in effect for the studies at the time the studies begin.

For encounter validation studies, AHCCCSA will select all approved and pended encounters to be studied no earlier than 240 days after the end of the month in which the service was rendered. Once AHCCCSA has selected CRSA' encounters for encounter validation studies, subsequent encounter submissions for the period being studied will not be considered.

AHCCCSA may review all of CRSA' submitted encounters, or may select a sample. The sample size, or number of encounters to be reviewed, will be determined using statistical methods in order to accurately estimate CRSA' error rates. Error rates will be calculated by dividing the number of errors found by the number of encounters reviewed. A ninety five percent (95%) confidence interval will be used to account for limitations caused by sampling. The confidence interval shows the range within which the true error rate is estimated to be. If error rates are based on a sample, the error rate used for sanction purposes will be the lower limit of the confidence interval.

Encounter validation methodology and statistical formulas are provided in the *AHCCCS Encounter Data Validation Technical Document*. This document also provides examples which illustrate how AHCCCSA determines study sample sizes, error rates, confidence intervals, and sanction amounts.

Written preliminary results of all encounter validation studies will be sent to CRSA for review and comment. CRSA will have 30 days to review results and provide AHCCCSA with additional documentation that would affect the final calculation of error rates and sanctions. AHCCCSA will examine CRSA' documentation and may revise study results if warranted. Written final results of the study will then be sent to CRSA and communicated to CMS, and any sanctions will be assessed.

CRSA may file a written challenge to sanctions assessed by AHCCCSA not more than 35 days after CRSA receives final study results from AHCCCSA. Challenges will be reviewed by AHCCCSA and a written decision will be rendered no later than 60 days from the date of receipt of a timely challenge. Sanctions shall not apply to encounter errors successfully challenged. A challenge must be filed on a timely basis and a decision must be rendered by AHCCCSA prior to filing a grievance pursuant to Article 8 of AHCCCS Rules. Sanction amounts will be deducted from CRSA' capitation payment.

Encounter Corrections

CRSA is required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCSA or CRSA. CRSA shall refer to the Encounter Reporting User Manual for instructions regarding submission of corrected encounters.

[END OF ATTACHMENT]

ATTACHMENT F: PERFORMANCE IMPROVEMENT PROJECT METHODOLOGY

Project Title: Improving Pediatric-to-Adult Transition Services

Background: Transition, as defined in a position paper from the Society for Adolescent Medicine, is “the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from a child-centered to adult-oriented health care system.” The position paper also promotes transition as an important component of high-quality health care.¹ Further, the Maternal and Child Health Bureau (MCHB) has identified transition as one of six core outcomes that, when achieved, will indicate successful progress toward the goal of a community-based system of services for children with special health care needs.²

In recent years, more and more youth with chronic conditions are surviving into adulthood. Each year, in the United States, nearly half a million children with special health care needs cross the threshold into adulthood.³ One generation ago, most of those with severe disabilities died before reaching maturity; now more than 90% survive to adulthood.⁴ Thus, transition planning has become even more important as a health care quality issue.

Transition planning is a complex process that needs to be individualized for each young adult and requires coordination with health care providers, family members, and all involved in the care of the young adult. Optimum transition plans include steps to assure that young adults will become independent, functioning adults in all aspects of their lives. Transition planning and services are components of the Medical Home model promoted by the American Academy of Pediatrics (AAP). Additionally, transition services and a plan are required for youth who receive services through the Individuals with Disabilities Education Act (IDEA) in their Individualized Educational Plan (IEP). This plan is required at age 14 years.

Given the national focus on transition issues and the designation of transition as a core outcome measure for children with special health care needs, the Arizona Department of Health Services (ADHS) Children’s Rehabilitative Services (CRS) recently implemented contractual requirements for transition activities. CRS contracts now require that transition services are initiated at age 14 years, are ongoing until exit from the CRS program, and are documented in the medical records of transitioning youth. The contract language regarding transition was developed based on the age at which the IEP plan addresses transition, and on lessons learned from MCHB’s Healthy and Ready to Work (HRTW) grant initiatives funded from 1996 to 2001.⁵

Per AHCCCS Medical Policy, ADHS/CRS carefully considered information from all potential sources in the selection and development of a Performance Improvement Project. Transition planning was identified as an area of concern. A presentation about Performance Improvement Project selection was given at a CRS Medical Directors/Administrators meeting in April of 2004. A survey of CRS Medical Directors and Administrators following the presentation identified transition planning as one suggested Performance Improvement Project. Transition as a potential project was discussed with OCSHCN Section Managers, the Quality Management section, and the Data, Planning, and Evaluation section. Additional support for transition as a performance improvement project was obtained via informal communications from CRS providers, health care providers in the community, and parents, who expressed that there is a need for improving the transition process for youth. Communications within the last year between the ADHS/CRS Medical Director and

AHCCCS health plans support the need for improvement in transition processes. Additionally, the AHCCCS/CRS Taskforce felt that transition was an important need and developed a transition checklist tool as an attempt to improve processes for transitioning youth.

Although family satisfaction with transition services is measured in the State and Local Area Integrated Telephone Survey (SLAITS), conducted on the national level, the most recent data from 2001 did not meet reliability and validity standards and thus, does not provide useful information on transition. The 2002 ADHS/CRS Family Centered Survey is one source of data available on family satisfaction regarding transition. Families were asked to identify priority areas for improvement in CRS. Help with transition to adulthood was ranked the third highest area in need of improvement. Anecdotally, we have been made aware via communications with parents and youth that transition planning is important, and that several barriers exist that limit effective transition.

Purpose:	The purpose of this project is to improve transition services for youth enrolled in the Children's Rehabilitative Services program, with the overall goal of improving successful transition to adulthood. Providing transition planning allows young people to optimize their ability to assume adult roles and functioning. Starting the transition process early in adolescence gives youth and their families time to plan and to address the many complex issues involved in transition. The project will measure whether transition planning is initiated and documented for youth enrolled in CRS, as is required by contractual agreement. Results will be analyzed and interventions developed to address the barriers to providing transition services.
Study Questions:	What percent of members within the measurement period(s) have a transition plan initiated and documented in the medical record by their 15th birthdays? How do the percentages compare by CRS contractor site?
Population:	CRS enrolled members who were concurrently enrolled in AHCCCS (Medicaid) or KidsCare.
Population Stratification:	Members will be stratified by CRS Regional Contractor site.
Population Exclusions:	Members who were not continuously enrolled in CRS for 12 months prior to and including their 15th birthdays. CRS members who were not concurrently enrolled in AHCCCS during the measurement period.
Population Sample Frame:	CRS members enrolled in AHCCCS or KidsCare who turned 15 years of age on or between July 1, 2003, and June 30, 2004, and were continuously enrolled for 12 months prior to and including their 15th birthdays.
Sample Selection:	CRS will select a representative, random sample of members, stratified by Regional Contractor, using a 95-percent confidence level and a confidence interval of +/-5 percent. Note: If sampling yields insufficient numbers to conduct analysis for any Regional Contractor site, all members in the sample frame for that site will be selected.

Indicator Descriptions:	The percent of enrolled members with a documented transition plan initiated by their 15th birthdays.
Indicator Criteria:	Documentation must include the date on which a transition plan was initiated, and must be in the member's medical record. The planning process may take place via telephone call or by patient encounter in a clinic. Mailing of an informational letter or packet without documentation of a subsequent telephone call or encounter to discuss transition is not sufficient documentation of a transition plan. Documentation must specifically reference transition, and must be documented by the 15th birthday.
Indicator Goal:	The overall goal is that 100 percent of enrolled members sampled will have documentation of an initial transition plan by their 15th birthdays, since this is a CRS contractual requirement. A minimum of 80 percent of sampled youth having a documented transition plan will be acceptable.
Minimum Performance Standard:	All CRS Regional Contractors will be required to develop and implement interventions if results show performance below the minimum acceptable goal of 80 percent of youth having a documented transition plan by their 15th birthdays.
Data Collection Tool:	A data abstraction tool will be utilized to review medical records submitted by the CRS Regional sites (see tool, Appendix A).
Data Source:	Transition plans from medical records of sampled members, as submitted by the CRS Regional Clinics.
Data Collection:	Review of transition plans from medical records of sampled members, as submitted by the CRS Regional Clinics. Review will be done by ADHS/CRS staff using a standardized data abstraction tool.
Confidentiality Plan:	<p>All member information is considered confidential and its security and privacy is protected. CRS will ensure that HIPAA and other applicable state and federal requirements are met, specifically:</p> <ul style="list-style-type: none"> • All forms, surveys, data disks, data CDs, and other communication formats that have member specific information will be stored in secure locations. • All shared information will be in aggregate form with no identifiers that could be associated with an individual member. <p>Anecdotal information may be used but all identifiers that could be associated with an individual member will be excluded.</p>
Data Validation/Reliability:	Multiple reviewers will each review a designated set of transition plans. The results of these reviews will be correlated for inter-rater reliability.
Denominator:	The number of CRS members who turned 15 years of age on or between July 1, 2003, and June 30, 2004, and who were continuously enrolled in CRS for 12 months prior to and including their 15th birthdays, and were concurrently enrolled in AHCCCS.
Numerator:	The number of members in the denominator who have a transition plan initiated and documented in the medical record by the 15th birthday.

Benchmark: CRS contracts require that transition planning is initiated and documented for enrolled members by age 14 years. The AAP, in conjunction with the American Academy of Family Physicians and the American College of Physicians-American Society of Internal Medicine has published a consensus statement that states youth with special health care needs should have adequate transition planning that starts at age 14 years.⁷ Additionally, the MCHB has designated the provision of services necessary to make transitions to adult life as a core outcome in its national action plan to achieve community-based service systems for children with special health care needs and their families.

Analysis, Intervention and Re-evaluation Plan: CRS will calculate the total number of youth in the sample with documented transition plans by their 15th birthdays as a statewide aggregate and by CRS Regional Contractor Site, as follows:

- Calculate the percentage of youth selected (N) who have documented transition plans during the study period from submitted CRS Regional Contractor medical records (A), as a statewide aggregate and by CRS Regional Contractor Site

$$\begin{array}{lcl} \text{\% of children with documented transition plan} & = & \frac{A}{N} \\ \text{initiated} & & \end{array}$$

A = Documentation of transition plan included in the medical record

N = Selected youth

- Compare the percentages Statewide and by Regional Site with the desired goal. Cohen's effect size will be used to determine if the difference between the actual and goal proportions is significant⁶

Barriers will be analyzed, based on results of the baseline data gathered, as well as data obtained from focus groups with CRS staff and a survey of CRS members/families to ascertain their satisfaction with the transition planning process.

CRS will implement interventions to improve transition services and/or sustain adequate transition services based on analysis of results. Interventions will be developed for each identified barrier. Trend analysis will be conducted to measure the improvement over time.

Future goals will focus on standardization of the transition process and services among Regional Contractor sites and incorporating best practices based on national guidelines, research, and quality tools, such as transition planning checklists, comprehensive resource sheets and educational services for youth and families. Additionally, CRS will focus specifically on coordination with schools in IEP development, and coordination with primary care providers. CRS also anticipates utilizing family/youth surveys and/or focus groups to ascertain the quality of transition services provided by CRS.

Comparative Analysis: Comparison of percentages will be made:

- Between the goal and statewide results;
- Between the goal and Regional Contractor results;
- Between Regional Contractors; and,
- Between measurement years after a baseline is established.

CRS is not aware of any similar program or health plan with which to compare results.

**Project
Timelines:**

By 10/1/05, ADHS/CRS will have established a baseline measurement from which to evaluate, will have proposed site-specific interventions, and will have proposed strategies to implement the interventions and evaluate post-implementation performance.

By 12/31/05, ADHS/CRS will have implemented the interventions.

By 10/1/07, ADHS/CRS will complete a re-measurement of performance, will conduct an analysis to compare the baseline results with post-intervention data for the re-measurement period (7/1/06-6/30/07), and will propose new interventions if goals are not met.

By 12/31/07, ADHS/CRS will implement new interventions, if necessary.

By 10/1/09, ADHS/CRS will undertake a second re-measurement and analyze results for the second re-measurement period (7/1/08-6/30/09).

If necessary, the cycle of development-analysis-evaluation will be repeated on a yearly basis until the statewide goal is reached.

Limitations:

One limitation is that the project focuses only on the initiation of transition services, rather than the full range of services provided for all CRS-enrolled youth from age 14 to 21 years. Future plans include a qualitative analysis of transition services.

Report Format:

The report will show results as an overall CRS percentage and also will show percentages by CRS Contractor site (see Appendix B). Barriers identified will be numbered and interventions will be documented to address each barrier. The intervention and evaluation summary format is also attached (see Appendix C). The report will be shared with appropriate ADHS/OCSHCN staff and CRS Contractors for the purpose of developing and implementing interventions. When applicable, information will be shared with the appropriate external entities to assist in further identification of interventions to improve transition services.

Definitions:

AAP:	American Academy of Pediatrics
ADHS:	Arizona Department of Health Services
CRS:	Children's Rehabilitative Services, a subdivision of ADHS. A section of the Office for Children with Special Health Care Needs whose mission is "to provide for medical treatment, rehabilitation, and related support services to medically and financially qualified individuals who have certain medical, disabling or potentially disabling conditions which have the potential for functional improvement."
CSHCN:	Children with Special Health Care Needs
Encounter:	A record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated Contractor on the date of service
Enrolled:	Means an individual who has a CRS condition, has attended the first clinic visit, and has completed both the CRS financial interview and has signed a CRS payment agreement. An enrolled member is an individual who has been granted entry to the CRS program, and who is eligible to receive CRS services
HIPAA:	Health Insurance Portability and Accountability Act of 1996. Personal Health Information (PHI) for all members is protected in accordance with the privacy requirements in Code of Federal Regulations (CFR) Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
IDEA:	Individuals with Disabilities Education Act-originated from the Education of the Handicapped Act, Public Law (P.L.) 94-142, which was passed by Congress in 1975, and amended by P.L. 99-457 in 1986 to ensure that all children with disabilities would have a free, appropriate public education available to them which would meet their unique needs. It was again amended in 1990 and the name was changed to IDEA.
IEP:	Individualized Educational Program, required for youth who receive services through IDEA
MCHB:	Maternal and Child Health Bureau
Member:	An individual who is enrolled in CRS and who is eligible to receive services from CRS providers.
NCHS:	National Center for Health Statistics
OCSHCN:	Office for Children with Special Health Care Needs. A section of the Arizona Department of Health Services whose mission is "to promote continuous improvement in the health, future and quality of life for adults

and children with special health care needs by building partnerships with families, communities, and providers, both public and private”.

Regional
Contractor:

A person contracted with ADHS to provide CRS Services.

SLAITS:

The State and Local Area Telephone Survey is a broad-based, ongoing surveillance system available at the state and local levels for tracking and monitoring the health and well being of children and adults. The National Survey for children with special health care needs is conducted as a module of SLAITS.

Transition:

Transitions, in general, are part of normal, healthy development and occur across the lifespan. Transition in health care for young adults with special health care needs is a dynamic, lifelong process that seeks to meet their individual needs as they move from childhood to adulthood.

References:

1. American Academy of Pediatrics, Committee on Children with Disabilities and Committee on Adolescence. Transition of Care Provided for Adolescents with Special Health Care Needs. *Pediatrics*. 1996; 98:1203-1206
2. Maternal and Child Health Bureau. *Achieving Success for All: Children and Youth With Special Health Care Needs. A 10-Year Action Plan to Accompany Healthy People 2010*. Washington, DC: Maternal and Child Health Bureau; 2001
3. Newacheck PW, Taylor WR. Childhood Chronic Illness: Prevalence, Severity, and Impact. *American Journal of Public Health* 1994;82:364-371
4. Blum RW. Transition to Adult Health Care: Setting the Stage. *Journal of Adolescent Health* 1995;17:3-5
5. www.hrtw.org
6. Cohen J. Statistical Power Analysis for the Behavioral Sciences. Lawrence Erlbaum Associates. Second Edition. 1988
7. American Academy of Pediatrics. Improving Transition for Adolescents With Special Health Care Needs from Pediatric to Adult-Centered Health Care. *Pediatrics*. 2002 n.6;110; 1304-1306.

[END OF ATTACHMENT]

APPENDIX A: PERFORMANCE IMPROVEMENT MEDICAL RECORD DATA ABSTRACTION TOOL

Improving Pediatric-to-Adult Transition Services

Date of Review:	
CRS Member Name:	
CRS Member ID:	
CRS member DOB:	

Documentation of Transition Planning	Yes	No
Does the member have a documented transition plan? If yes, Record Date transition plan was initiated _____		
Was the transition planning process initiated by: (answer for all)		
Telephone call		
Clinic encounter		
If the transition plan was not initiated via telephone call or clinic encounter, is it documented that an informational packet or letter was sent? If yes, record date information/packet was sent _____		

[END OF APPENDIX]

APPENDIX B: PERFORMANCE IMPROVEMENT PROJECT RESULTS

Improving Pediatric-to-Adult Transition Services

Statewide Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Northern Region Percentage of Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Central Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Southern Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Western Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	

[END OF APPENDIX]

**APPENDIX C: PERFORMANCE IMPROVEMENT PROJECT INTERVENTION AND EVALUATION
SUMMARY FORMAT**

Improving Pediatric-to-Adult Transition Services

Results Summary

Regional Contractor:	PIP: Improving Pediatric to Adult Transition Services for Youth
Goal: 80% of sampled youth with transition plan initiated by 15 th birthday	Result:
Strengths:	

Action Plan

Barrier	Intervention	Action Steps	Target Date	Evaluation

[END OF APPENDIX]

ATTACHMENT G: CRSA'S FINANCIAL REPORTING GUIDE

**STATE OF ARIZONA
CHILDREN'S REHABILITATIVE SERVICES (CRS)**

Medicaid Managed Care Program

FINANCIAL REPORTING GUIDE

FOR

CRS Contractors

State of Arizona
Arizona Department of Health Services
Office of Children with Special Health Care Needs (OCSHCN)

Issue Date: January 2004

1.00 Purpose and Objective of the Guide

The purpose of the Financial Reporting Guide For CRS Contractors (Guide) is to set forth the quarterly and annual financial reporting requirements for CRS Contractors under contract with the Arizona Department of Health Services / CRS Administration (CRSA).

The primary objective of the Guide is to establish consistency and uniformity in financial reporting among CRS Contractors. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor's annual certified audit, nor to replace the independent certified public accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the independent certified public accountant on an annual basis and by the applicable CRS Contractor management on a quarterly basis.

1.01 Background

In July 2000, the Arizona Department of Health Services implemented a diagnosis based capitation rate system which provides coverage for CRS medical services for Title XIX and Title XXI eligible children under the age of 21 years old that have been determined to have a CRS eligible condition and are enrolled with a CRS Contractor. The goal of the managed care clinic-based delivery system is to administer innovative managed care programs effectively and efficiently, and continually improve accessibility and delivery of quality health care to eligible members through integrated health care systems.

1.02 Effective Dates and Reporting Time Frames

The provisions and requirements of this Guide are effective for calendar quarters beginning on and after January 1, 2004. As deemed necessary, amendments and/or updates to this Guide may be issued by the CRS Administration. CRS Contractors will be given the opportunity to submit their comments before changes are implemented.

Quarterly reporting is due within **45** days of each quarter end. A draft of the annual audited financial statements and management letter is not required, but is encouraged to be submitted within **90** days of the CRS Contractor's calendar year end. Final annual financial reports are due within **100** days of the CRS Contractor's calendar year end.

For selected reports, the CRS Contractor is required to follow a predetermined format for reporting enrollment and financial data.

The following table depicts the overall reporting requirements and scheduling.

Report #	Report Name	Frequency	Due Date ¹	Format
1	Enrollment	Quarterly	45 Days After Quarter End	Predetermined
2	Balance Sheet	Quarterly	45 Days After Quarter End	Predetermined
3	Analysis of Revenue and Expenses	Quarterly	45 Days After Quarter End	Predetermined

Report #	Report Name	Frequency	Due Date ¹	Format
4	Claims Payable (RBUCs and IBNRs)	Quarterly & Annual	45 Days After Quarter End	Predetermined
5	Claims Lag Report	Quarterly	45 Days After Quarter End	Predetermined
N/A	Footnotes	Quarterly	45 Days After Quarter End	Predetermined Minimums
N/A	Certification Statement	Quarterly	45 Days After Quarter End	Predetermined
N/A	Draft Annual Audit Report	Annual	90 Days After Year End	N/A
N/A	Draft Management Letter (Encouraged but not required)	Annual	90 Days After Year End	N/A
N/A	Final Annual Audit Report	Annual	100 Days After Year End	N/A
N/A	Final Management Letter	Annual	100 Days After Year End	N/A
N/A	Annual Reconciliation Report	Annual	100 Days After Year End	Suggested

¹ If a due date falls on a weekend or State recognized holiday, reports will be due the next business day.

2.00

General Instructions and Submission

The following are general instructions for completing the various quarterly reports required to be submitted by the CRS Contractor to the CRSA. The primary objective of these instructions is to promote uniformity in reporting and to ensure that the financial statements and reports are prepared in accordance with generally accepted accounting principles.

Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports.

All quarterly or annual reports must be completed and submitted to the CRSA within the due date. The CRSA may extend a report deadline if a request for an extension is communicated, in writing, and is received at least ten business days prior to the report deadlines. Request for extension must include the reason for the requested extension and the date by which the report will be filed.

The CRS Contractor must submit the forms on diskette or via e-mail. **A signed and dated Certification Statement is required for all quarterly report submissions.**

Each report submission (either on diskette or e-mail) should be accompanied by a printed copy for reference and verification. All reports should be addressed to the following person and address:

Cynthia Layne, Finance & Business Operations Manager
CRS Administration
150 North 18th Avenue, Suite 330
Phoenix, AZ 85007-3243

Phone: (602) 542-2879
Fax: (602) 542-2589
Email: clayne@hs.state.az.us

Normally, line titles and columnar headings of the various reports are self-explanatory and therefore constitute instructions. However, specific instructions are provided for items that may have some question as to content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Always utilize predefined categories or classifications before reporting an amount as "OTHER". For any material amounts included in the "OTHER" category, **provide details and explanations**. For this purpose, **material** is defined as comprising an amount $\geq 5\%$ of the total for each section. For example, if Other Income is reported that is less than 5% of Total Revenues, no disclosure is necessary. However, if Other Medical Expense is reported which equals 8% of Total Medical expenses, disclosure would be necessary. Disclosure, with detail explanation, should be prepared in a separate sheet accompanied with the report.

Unanswered questions and blank lines or schedules will not be considered properly completed. If no answers or entries are to be made, write "None", not applicable (N/A), or "-0-" in the space provided.

All amounts are to be reported in whole dollars only. The CRS Contractor may elect to report the amounts to the nearest whole dollar or through truncation of digits less than a dollar. (Examples: \$504,932.65 may be reported as \$504,933 by rounding or as \$504,932 by truncation).

3.00 General Information – Quarterly Reporting

The following financial statements are to be reported on a quarterly basis. See Section 1.02 for the due dates of these reporting requirements.

- Certification Statement
- Enrollment (Report #1)
- Balance Sheet (Report #2)
- Analysis of Revenues and Expenses (Report #3)
- Claims Payable (RBUCs and IBNRs) (Report#4)
- Claims Lag Report (Report #5)
- Footnotes

3.01 Report #1 – Enrollment Table

Member Month Equivalents – These columns disclose member month equivalents per

month by high, medium and low risk categories and for the state only category as shown on the report. A member month is equivalent to one member for whom capitation-based revenue has been recognized for the entire month. Where revenue is recognized for only part of a month for a given individual, a partial, pro-rated member month should be counted. A partial member month is pro-rated based on the actual number of days in a particular month.

Year-to-Date (YTD) – The year-to-date column should equal the sum of as many months as have been completed through the quarter being reported. For example, after the first quarter, the year-to-date column will equal the first three months' numbers, but after the second quarter, the year-to-date column will equal the sum of the first six months.

3.02

Report #2 – Balance Sheet

CURRENT ASSETS are assets that are expected to be converted into cash or used or consumed within one year from the date of the balance sheet. Restricted assets for the general performance bond, contracts, reserves, etc., are not to be included as current assets.

Minimum Specification	Inclusion	Exclusion
<i>Cash and Cash Equivalents</i>	Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any cash (and equivalents) pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Short-term Investments	Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date. Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Accounts Receivable	Includes monies due the Contractor for services rendered for which payment has not yet been received	
Investment Income Receivable	Income earned but not yet received from cash equivalents, investments, performance bonds, and short and long-term investments.	
Other Current Assets	Include all other current assets not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for here. They should not be netted against the IBNRs. Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

CURRENT LIABILITIES are obligations whose liquidation is reasonably expected to occur within one year from the date of the balance sheet.

Minimum Specification	Inclusion	Exclusion
<i>Accounts Payable</i>	Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.	Amounts due to providers related to the delivery of health care services.
Accrued Administrative Expenses	Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.	
Medical Claims Payable (Detail in Report #4)	The total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs).	
Management Fee Payable to Parent Company	Includes all management services and/or corporate cost allocation plans. Note, the CRSA reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If the fees or allocations actually paid out are determined to be unjustified or excessive, appropriate actions will be taken. Also, material amounts (greater than 5% of total liabilities) should be disclosed and fully explained in a separate sheet.	
Other Current Liabilities (Specify)	Those current liabilities not specifically identified elsewhere. Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

EQUITY includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

Minimum Specification	Inclusion	Exclusion
<i>Preferred Stock</i>	Should equal the par value, or in the case of no-par shares, the stated or liquidation value, per share multiplied by the number of issued shares.	
Common Stock	Should equal the par value, or in the case of no-par shares, the stated value, per share multiplied by the number of issued shares.	
Additional Paid-in Capital	Amounts paid and contributed in excess of the par or stated value of shares issued.	
Contributed Capital	Capital donated to the CRS Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.	
Retained Earnings	The undistributed and unappropriated amount of earned surplus.	

3.03 **Report #3 – Analysis of Revenues and Expenses**

Report revenues and expenses using the full accrual method according to GAAP.

MEMBER MONTH EQUIVALENTS Automatic transfer of information from Report #1 – Enrollment Table.

REVENUES All revenues should be reported by rating category (Category of High, Medium, Low, State Only, and other).

Minimum Specification	Inclusion	Exclusion
Capitation Revenue	Revenue recognized on a prepaid basis for provision of covered services.	
Investment Income	All investment income earned during the period.	Do not net interest income and interest expense together.
Fixed fee – State only	All State only income earned during the period	
Other Income (Specify)	Revenue from sources not identified in the other revenue categories. Note, material amounts (greater than 5% of total revenues) should be disclosed and fully explained in a separate sheet.	

MEDICAL EXPENSES All medical expenses must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Hospital Inpatient – In State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital, including out of area (OOA) hospitalization.	Do not include inpatient costs provided in an out of state facility.
Hospital Outpatient – In State	The facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include outpatient costs provided in an out of state facility.
Hospital Inpatient / Outpatient – Out of State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital. Also include the facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include inpatient or outpatient costs that were provided in state.
Physician – Regional Clinic	All costs associated with medical services provided by a physician or other practitioner in a regional clinic including only non-salaried physicians and other non-salaried practitioners that are compensated on a fee for service, hourly, session	Do not include any physician costs for salaried physicians or salaried other practitioners

Minimum Specification	Inclusion	Exclusion
	rate basis or comparable basis.	
Physician – Outreach Clinic	All costs associated with medical services provided by a physician in an outreach clinic including only non-salaried physicians and other non-salaried practitioners that are compensated on a fee for service, hourly, session rate basis or comparable basis.	Do not include any physician costs for salaried physicians or salaried other practitioners
Physician – Non Clinics	All costs associated with medical services provided by a physician or other practitioner in a setting other than a regional or outreach clinic.	Do not include physician costs provided in a regional or outreach clinic setting. or salaried physicians or other practitioners
Clinic – Professional Staff (Salaried)	All costs (including payroll taxes) associated with medical services provided by physicians, other practitioners, and medical personnel in a regional clinic including only salaried personnel.	Exclude costs for physician, other practitioner, and other medical staff that are not considered part of the CRS Contractor staff.
Medical Support Administration - Clinics	All other costs related to the provision of medical services within a regional or outreach clinic. Costs should include allocation of rent, depreciation, telephone, and other utilities.	Non-Clinic Administration
Medical Supplies and Other Costs - Clinics	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach clinic setting.	
Pharmacy	Expenses for drugs provided that include both ingredient costs and dispensing fees. Also include any clinical staffing and related administrative pharmacy costs.	
Durable Medical Equipment	The cost of durable medical equipment (DME).	
All Other Medical	All other medical costs not related to any of the above categories of service.	
Non Covered Services	All costs for services not specifically identified as a CRS covered Service	

REINSURANCE and THIRD PARTY LIABILITY All reinsurance and third party liability recoveries must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Reinsurance	All reinsurance expected to be recovered from the State or reinsurance company under a reinsurance agreement.	
Third Party Liability	Cost sharing revenue, including third party sources.	

ADMINISTRATION All administrative costs must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Administrative Compensation	All costs (including payroll taxes) associated with non-clinical administrative services provided by personnel in a regional or outreach clinic.	Administration - Exclude Administrative Fees owed to Parent Company
Interest expenses	Interest expenses	Do not net interest income and interest expense together.
Occupancy, Depreciation & Amortization	Occupancy, Depreciation & Amortization costs related to services provided in a regional or outreach clinic	
Administrative Allocations from Affiliate/Parent	Administrative costs allocated to the CRS Contractor for the current period by a parent or affiliate management company.	

3.04 **Report #4 – Medical Claims Payable (RBUCs and IBNRs)**

Reported but unpaid claims (RBUCs) are to be reported by the appropriate expense categories. A claim becomes an RBUC the day it is received by the CRS Contractor, not the day it is processed/adjudicated. The incurred but not reported (IBNR) claims should be reported in the second to last column by the appropriate category.

3.05 **Report #5 – Claims Lag Reports**

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. The following information is provided as guidelines to help make this analysis (also see Appendix C).

Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. All CRS Contractors should use lag information as a validation test for accruals calculated using other methods, if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid by the CRS Contractor on the other axis (vertical). Remember, it is best to track specific information by population risk group and by category of service, as each population may have different characteristics.

Once a number of months becomes "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are

submitted historically and applying this information to months which are not yet fully developed.

Although not currently required, a separate table could be completed for the following categories of service:

- 1) Hospital
- 2) Physician
- 3) All Other

Claims Lag Table Example

The following simple example demonstrates the lag table approach discussed above.

Fully Developed Table						
<u>Month Incurred (Date of Service)</u>						
<u>Month Paid</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>Total</u>	<u>Percent of Total</u>	<u>Cumulative Percent</u>
Current	\$ 1,400	\$ 800	\$ 2,000	\$ 4,200	10.0%	10.0%
1st Prior	\$ 8,200	\$ 8,750	\$ 8,500	\$25,450	60.6%	70.6%
2nd Prior	\$ 3,700	\$ 2,800	\$ 3,750	\$10,250	24.4%	95.0%
3rd Prior	<u>\$ 700</u>	<u>\$ 650</u>	<u>\$ 750</u>	<u>\$ 2,100</u>	<u>5.0%</u>	<u>100.0%</u>
TOTAL	<u>\$14,000</u>	<u>\$13,000</u>	<u>\$15,000</u>	<u>\$42,000</u>	<u>100.0%</u>	

This table indicates that 10% of all claims are reported and paid in the month services are rendered; in the next month, 60.6% of the claims are paid; and so on. In this example, all claims are shown to be paid within four months from the date of service (i.e., fully developed). This may be unrealistic but it satisfies the needs of this example. The above information can be used to calculate IBNRs by looking at claims payment experience for the three months prior to the balance sheet date.

By dividing claim payments to date by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate is made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims expense accrual.

The following steps must be taken:

In order to estimate the total claims expense as of the end of June,

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.
2. Subtract all claims already paid or received (RBUC's) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

Month Incurred

<u>Month Paid</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>Total</u>
Current	\$ 1,600	\$ 1,900	\$1,600	\$ 5,100
1st Subsequent	\$ 9,700	\$10,600	\$ -----	\$20,300
2nd Subsequent	\$ 3,800	\$ -----	\$ -----	\$ 3,800
3rd Subsequent	<u>\$-----</u>	<u>\$ -----</u>	<u>\$ -----</u>	<u>\$ -----</u>
TOTAL	\$15,100	\$12,500	\$1,600	\$29,200
Divided by Cumulative				
Percent Paid	<u>95.0%</u>	<u>70.6%</u>	<u>10.0%</u>	<u>N/A</u>
Estimated Total				
Claims Expense	\$15,895	\$17,705	\$16,000	\$49,600
Less: Amount				
Paid to Date	(15,100)	(12,500)	(1,600)	(29,200)
Less: RBUC's	<u>(100)</u>	<u>(200)</u>	<u>(1,100)</u>	<u>(1,400)</u>
Estimated Claims Accrual	<u>\$695</u>	<u>\$5,005</u>	<u>\$13,300</u>	<u>\$19,000</u>
(IBNR)				

It should be noted that the estimates developed by this lag technique should be monitored for reasonableness. This is especially true for the most recent months where the information is less developed than the older months. If the calculation is producing an unusually low or high total claims expense for any particular month it should be investigated for validity. An example of a possible solution is to override the skewed portion of the IBNR with an average monthly cost less the amount paid to date for that month.

3.06 Footnotes

The Contractor shall prepare footnote disclosures to accompany each set of quarterly financial reports. The footnotes should provide sufficient detail and complete disclosure of significant accounting assumptions, estimates, and changes in financial condition and significant ownership/control relationships.

In addition, the Contractor shall report the pricing methodology utilized to determine medical expenditures for the period. This shall be done at the same level of detail as is required for medical expenditures in Report #3 – Analysis of Revenues and Expenses. If multiple pricing schemes are utilized by the Contractor for a particular category of service, disclose the most prevalent approaches utilized (based on total expenditures). For example, if the Contractor reimburses inpatient hospital service providers using a percentage of billed charges approach for affiliated entities and out-of-state hospitals, and the AHCCCS tiered per-diem schedule for unaffiliated hospitals in state, both should be disclosed, along with the percent of billed charges paid to affiliates and non affiliated providers. The table below should be utilized for these disclosures.

Sample Disclosure Table

Categories of Service	Method of Reimbursement/Basis of Expense Recognition	Approximate Percentage of Expenditures
<i>Hospital Inpatient – In State</i>	1) Affiliated Hospitals – Percentage of billed charges (60%) 2) Non-Affiliated Hospitals – AHCCCS Tiered Per Diem	1) 95% 2) 5%
Hospital Outpatient – In State	1) Affiliated Hospitals – Percentage of billed charges (55%) 2) Non-Affiliated Hospitals – AHCCCS cost-to-charge ratio	1) 90% 2) 10%
Hospital Inpatient / Outpatient – Out of State	1) Percentage of billed charges (varies by contract) 2) Negotiated rate per patient	1) 60% 2) 40%
Physician – Regional Clinic	1) Physicians – Percent of Billed Charges (80%) 2) Physicians – Percent of AHCCCS FFS rates (95%) 3) Non-Physicians – Hourly rate (per contract)	1) 40% 2) 30% 3) 30%
Physician – Outreach Clinic	1) Physicians – Percent of Billed Charges (850%) 2) Physicians – Percent of AHCCCS FFS rates (100%) 3) Non-Physicians – Hourly rate (per contract)	1) 60% 2) 10% 3) 30%
Physician – Non Clinics	1) Physicians – Percent of Billed Charges (70%) 2) Physicians – Percent of AHCCCS FFS rates (105%) 3) Non-Physicians – Hourly rate (per contract)	1) 20% 2) 65% 3) 15%
Clinic – Professional Staff (Salaried)		
Medical Support Administration - Clinics		
Medical Supplies and Other Costs -	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach	

Categories of Service	Method of Reimbursement/Basis of Expense Recognition	Approximate Percentage of Expenditures
Clinics	clinic setting.	
Pharmacy	Discount - AWP less 15% Dispensing Fee - \$2.75 Administration Fee – Not applicable	100% 100%
Durable Medical Equipment	AHCCCS FFS Fee Schedule	100%
All Other Medical		
Non Covered Services		

4.00 General Information – Annual Reporting

The CRS Contractor is required to submit certain financial reports and schedules to the CRSA on an annual basis. See Section 1.02 for the due dates of the annual reporting requirements.

The annual financial reports and schedules must disclose the CRS line of business (including assets, liabilities, equity, revenue, and expenses) independent of any other line of business in which the CRS Contractor may be engaged.

For example, if a CRS Contractor also has a contract to provide services not related to its CRS Contract with ADHS, the financial statements must at least separate these lines of business in the form of additional supplemental schedules, if they are not separately presented in the financial statements themselves. In addition, **all required supplemental schedules listed in Section 4 are to represent the CRS line of business exclusively.**

4.01 Required Statements and Supplemental Schedules

The following statements and schedules must be included in the audited financial statements accompanied by an independent certified public accountant's report thereon.

- Balance Sheet
- Statement of Revenues and Expenses and Changes in Equity/Net Assets
- Footnotes

Other required, supplemental schedules include:

- Claims Payable (See Report #4)
- Final Management Letter
- Annual Reconciliation Report

4.02 Annual Reconciliation Report

In addition to the annual audited financial statements, a reconciliation of the CRS Contractor's final year-to-date quarterly financial statements to the annual audited statements must be submitted with the final audited statements. (See Appendix B for example)

5.00 Glossary of Terms

CAPITATION. A fixed premium that is paid per eligible member periodically (usually monthly) to a contractor or subcontractor as compensation for providing health care services for the period.

CRS CONTRACTOR. Organization or entity agreeing through a direct contracting relationship with the ADHS/CRS Administration to provide those goods and services specified by contract.

DAY. Day means calendar day unless otherwise specified.

ENROLLMENT. Process by which a person who has been determined eligible becomes qualified to receive CRS covered services from a CRS Contractor.

FEE-FOR-SERVICE. Payment mechanism by which contractors, subcontractors and other providers of care are reimbursed upon submission of valid claims for specific covered services and equipment provided to eligible persons.

INCURRED BUT NOT REPORTED CLAIMS (IBNRs). The liability for services rendered for which claims have not been received.

INPATIENT. A patient who is provided with room, board, and general nursing service in a hospital setting and is expected to remain at least overnight and occupy a bed.

OUTPATIENT. A patient who is not confined overnight in a health care institution.

PHARMACY. Establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist.

PROVIDER. A person or entity that undertakes to provide health care services.

RELATED PARTY TRANSACTIONS. Transactions, whether or not in the ordinary course of business, with directors, management, medical staff, or other related parties.

REPORTED BUT UNPAID CLAIMS (RBUCs). A claim is considered received the day it is physically received at the CRS Contractor.

THIRD PARTY. An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

6.0 Appendices

- (A) Quarterly Certification Statement
- (B) Reconciliation - Annual Audit and CRS Contractor Year End Quarterly Financial Statements
- (C) Medical Claims Payable (RBUCs and IBNRs) General Information

[END OF ATTACHMENT]

APPENDIX A: QUARTERLY CERTIFICATION STATEMENT

QUARTERLY CERTIFICATION STATEMENT OF

<CRS CONTRACTOR NAME>

TO THE

Arizona Department of Health Services

FOR THE QUARTER ENDED

_____, 200____
(Month and Day) (Year)

Name of Preparer _____

Title _____

Phone Number (____) _____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge and has been prepared in accordance with the reporting instructions provided by the State. Any variances from GAAP in preparing this information have been identified and disclosed in writing to the State. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in the termination of a Program Contractor's agreement or contract with the Arizona Department of Health Services. **Failure to sign the Certification Statement will result in ADHS' non acceptance of the attached reports. Attached is the methodology used to create these financial statements.**

Date Signed

Chief Executive Officer
(Name and Title typewritten)

Signature

Date Signed

Chief Financial Officer
(Name and Title typewritten)

Signature

[END OF APPENDIX]

APPENDIX B: ANY CRS CONTRACTOR RECONCILIATION

Annual Audit and CRS Contractor Year End Quarterly Financial Statements

For the Period Ended June 30, 200X

	YTD Quarterly Reporting	Increase / (Decrease)	Final Audit
<u>Balance Sheet:</u>			
Receivable from the ADHS	\$2,400,000	\$100,000	\$2,500,000 (a)
Medical Claims Payable	<u>1,392,500</u>	<u>(142,500)</u>	<u>1,250,000 (b)</u>
Change in Equity / Net Assets:	<u>\$3,792,500</u>	<u>\$(42,500)</u>	<u>\$3,750,000</u>
<u>Statement of Revenues & Expenses:</u>			
Capitation Revenue	\$1,100,000	\$100,000	\$1,200,000 (a)
Hospital Inpatient	9,090,000	(90,000)	9,000,000 (b)
Physician – Regional Clinic	7,892,500	(45,000)	7,847,500 (b)
All Other Medical	<u>4,507,500</u>	<u>(7,500)</u>	<u>4,500,000 (b)</u>
Change in Net Income(Loss):	<u>\$22,590,000</u>	<u>\$(42,500)</u>	<u>\$22,547,500</u>

- (a) Additional capitation revenue was identified by a reconciliation notice from ADHS.
- (b) Balances for medical claims payable and expense changed due to revisions of IBNR estimates based upon subsequent claims payments.

[END OF APPENDIX]

APPENDIX C: MEDICAL CLAIMS PAYABLE (RBUCS AND IBNRS) GENERAL INFORMATION

There are three primary components of claims expense:

Paid claims,

Received but unpaid claims (RBUcs). Note that a claim is considered an RBUC immediately upon receipt by the CRS Contractor and should be tracked as such. The processing status of an RBUC is either pended, in process, or payable, and

Incurred but not reported claims (IBNRs).

The first two components of claims expense are readily identifiable as part of the basic accounting systems utilized by the CRS Contractors. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important that CRS Contractors have adequate claims accrual and payment systems. These systems must be capable of reporting claims on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that the CRS Contractors continually monitor them with reference to reported and paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered:

Changes in policy, practice, or coverage

Fluctuations in enrollment by rate code category

Expected inflationary trends

Trends in claims lag time

Trends in the length of hospital inpatient stay by rate code category

Changes in rate code case mix

Changes in contractual agreements

IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred by the CRS Contractors, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and a logical IBNR methodology are required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a CRS Contractor's own circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review, and discharge planning functions. Also, the CRS Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to CRS Contractor members.

2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a proforma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., RBUCs and paid claims).
3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). This prospective claims data, together with claims data collected as the services are provided, should be used to identify claims liabilities.
4. Claims data should also be segregated to permit analysis by major risk group and category of service.
5. Subcontractor agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood and followed consistently by each party.
6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a CRS Contractor's IBNR methodology if applicable.

There are several different methods that can be used to determine the amount of IBNRs. The CRS Contractor should employ the one that best meets its needs and accurately estimates its IBNRs. **If a CRS Contractor is utilizing a method different from the methods included herein, a detailed description of the process must be submitted to the ADHS/CRS Administration for approval.** The IBNR methodology used by the CRS Contractor must be evaluated by the CRS Contractor's independent accountant or actuary for reasonableness.

Case Basis Method

Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost can be made after the services have been authorized by the CRS Contractor. For example, if a CRS Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

Average Cost Method

As the name suggests, average costs of services are used to estimate total expense. The expenses estimated using average costs are then reduced by claims that have been paid or claims that have been received but are unpaid (RBUCs). There are two primary average cost methods which are discussed below. It is important to note that each method may be used by a CRS Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. all other medical). Also, either method may be utilized in conjunction with other IBNR methodologies discussed in this document.

Per Member Per Month (PMPM) Averages

Under this method the average costs are based on the population rate for each risk group over a given time period, in this case one month. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid and RBUCs for the service category are subtracted from the expense estimate which results in the IBNR liability estimate for that service category.

Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the CRS Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get the IBNR liability. This method is primarily used for hospitalization IBNRs as CRS Contractors know the amount of hospital days authorized at any given time.

[END OF APPENDIX]